RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

BasicCare Program

Enrollment Form

You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.

SECTION A — INFORMATION ABOUT YOU

Social Security Number | First Name | Middle Initial | Last Name

Mailing Address: Street | City

State | Zip | Home Phone Number | Birth Date: Month | Day | Year | Sex: ☐ M ☐ F

C R A F T W O R K S H O L D

Name of Employer | Work Phone Number

SECTION B — ENROLLMENT SELECTION

It is important that you follow the directions when making your elections; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section C; otherwise, their enrollment may be delayed. Costs listed below are **weekly** amounts.

Make your selection by putting an [X] in the box next to the selection you want. List your Dependents on the back of this form.

	BasicAdvantage Total & Essential Plans*	Dental Plan
Employee Only	☐ $ 17.07	☐ $ 4.45
Employee + Spouse	☐ $ 33.56	☐ $ 9.39
Employee + Child(ren)	☐ $ 40.86	☐ $ 10.10
Employee + Family	☐ $ 58.15	☐ $ 14.95
DECLINE COVERAGE	☐	

* The costs shown may include amounts paid for Affordable Care Act taxes and fees that are in addition to the Essential plan's premium.

I wish to participate in the benefit plan(s) that I've selected above and I authorize my employer to deduct, on a pretax basis, the required costs from my paycheck.

Your Signature

Today's Date: Month Day Year

(OVER PLEASE)

SECTION C — WHICH DEPENDENTS WILL BE COVERED?

1. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total & Essential Plans ☐ Dental Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

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2. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total & Essential Plans ☐ Dental Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

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3. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total & Essential Plans ☐ Dental Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

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4. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total & Essential Plans ☐ Dental Plan

Birth Date: Month Day Year

Social Security # : — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

Address of Dependent not living with you:

First Name | Middle Initial | Last Name

Mailing Address: Street | City | State | Zip

If you have additional dependents or addresses for those dependents not living with you, please record all requested information on a separate sheet and attach it to this form.

There may be events that will allow you to enroll yourself and your eligible dependents outside of the Open Enrollment Periods. Please ask your employer for a Life Event Change Form which must be used for the additions or changes to benefits (including Special Enrollments), outside of an Open Enrollment Period.
