RELIANCE STANDARD LIFE INSURANCE COMPANY
EMPLOYER QUESTIONNAIRE FOR GROUP LONG TERM DISABILITY
CONVERSION INSURANCE

This form is to be completed by the Employer when a person desires and is eligible to convert his Group Long Term Disability insurance to Long Term Disability conversion coverage. The second side is to be completed by the employee and submitted, with premium, to The Company within 31 days following the date of termination of insurance.

1. Employee's full name ______________________________

2. Name of Group Policyholder ___________________________

   Group Policy No. __________ Federal Employer ID No. __________

   Branch or Location (if different from Policyholder) _________________

3. Employee's Date of Hire _____________________________

4. Employee's effective date of insurance under your Group LTD policy: ________

5. Date person last worked ________ Date insurance terminated _______

6. If dates differ in (5), please explain ________________________

7. Employee's occupation on the termination date __________________

8. Employee's last Basic Monthly Earnings before termination ____________

9. Date notice of conversion privilege was given to employee _____________

10. Was the employee covered under your present LTD policy for 12 consecutive months? _____Yes _____No

11. Did the employee leave as a result of retirement? ______Yes ______No

12. Is the employee now disabled from a Sickness or Injury? _____Yes _____No

13. Is there a disability claim for this employee pending for a disability benefit under your LTD Policy? _____Yes _____No

To the best of my knowledge the above information is correct and complete.

____________________________ ______________
Preparer's Signature and Title Date

RELIANCE STANDARD LIFE INSURANCE COMPANY
GROUP LONG TERM DISABILITY CONVERSION APPLICATION

The information below must be completed by the Employee and submitted, with premium and one time initial Application fee of $10.00, to The Company within 31 days following the date of termination of insurance.

SEND TO: Reliance Standard Life Insurance Company
Attention: Agency Licensing – Lynne Sellers
2001 Market Street, Suite 1500
Philadelphia, Pennsylvania 19103

1. Insured Person's full name ____________________________

2. Home Address (Street & No.) ___________________________

City _________ State __________ Zip Code __________

3. Sex __M __F

4. Social Security No. ____-___-____

5. Date of Birth ___-___-___

6. Are you covered for any other Group Long Term Disability insurance?
___Yes ___No

7. Premium Mode: Quarterly _____ Semi-Annual _____ Annual _____

The statements set forth above and on the reverse side are true to the best of my knowledge and belief.

____
Signature of Applicant

____
Date