

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

