

FIRST RELIANCE STANDARD

Life Insurance Company

a DELPHI company

CONFIRMATION OF PLAN INFORMATION

Due to the importance of this information, we request that the Policyholder applying for coverage fill out this form. The information provided will impact the way we adjudicate claims under the requested First Reliance Standard Life policy.

Customer Information

Full Legal Name of Organization _____
(Exactly as it is to appear in your contract and booklets)

When did the company start business operations? Month _____ Year _____

Contact Person(s):

Executive: _____ Title: _____
Phone Number: _____ Extension: _____ Fax Number: _____ E-mail: _____

Routine: _____ Title: _____
Phone Number: _____ Extension: _____ Fax Number: _____ E-mail: _____

General Coverage Information

Please select one option only, if options vary by class, please provide information for each class.

Eligible Employee Definition

Each Active Full-Time* Part-Time** Other _____
 Exempt Non-exempt Salaried Hourly Non-union Union Employee~

*Full-time means working a minimum of _____ hours per week. Excludes seasonal or temporary employees.

**Part-time means working a minimum of _____ hours per week. Excludes seasonal or temporary employees.

~Please note, if this definition is applicable, we will require a copy of the bargaining agreement

Service Waiting Period

Employees _____ Days Weeks Months
Is the waiting period waived for employees who have not met their service requirement? No Yes

Benefit Change Date

The Date First of the month coinciding with or next following _____

Individual Effective Date

The Date First of the month coinciding with or next following _____

Individual Termination Date

The Date First of the month coinciding with or next following _____

Earnings Definition

- Base Salary Only, Excludes Commission, Overtime, Bonuses etc.
- Base Salary plus commission averaged over _____ months, Excluding Overtime, Bonuses etc.
If commissions are included, list job titles to whom commission is paid: _____
- Other: (sales, K-1, W2, etc.) _____

Please note, all earnings definitions standardly include pre-tax deferrals. If "Other" is chosen, please detail averaging time period and included/excluded items.

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Sold Plan Design Information (or attach sold proposal)

Life/AD&D Eligibility	Plan Type	Plan Design
Class 1	<input type="checkbox"/> Flat Benefit <input type="checkbox"/> Multiple of Salary*	\$ _____ x BAE, max \$ _____
Class 2	<input type="checkbox"/> Flat Benefit <input type="checkbox"/> Multiple of Salary*	\$ _____ x BAE, max \$ _____
Class 3	<input type="checkbox"/> Flat Benefit <input type="checkbox"/> Multiple of Salary*	\$ _____ x BAE, max \$ _____
Class 4	<input type="checkbox"/> Flat Benefit <input type="checkbox"/> Multiple of Salary*	\$ _____ x BAE, max \$ _____

*Unless noted otherwise, benefits will be rounded to the next higher \$1,000.

LTD Eligibility	Plan Design
Class 1	_____ % to \$ _____ maximum, _____ day elimination, _____ own occupation
Class 2	_____ % to \$ _____ maximum, _____ day elimination, _____ own occupation

STD Eligibility	Plan Design
Class 1	_____ % to \$ _____ maximum, _____ day accident, _____ day sickness, _____ week duration
Class 2	_____ % to \$ _____ maximum, _____ day accident, _____ day sickness, _____ week duration

Employee/Employer Contributions

Please note the percentage of the cost or the dollar amount contributed by:

Line of Coverage	Employer	Employee	Line of Coverage	Employer	Employee
Basic Life	_____	_____	Voluntary Life	_____	_____
Basic AD&D	_____	_____	Voluntary AD&D	_____	_____
Supplemental Life	_____	_____	Short Term Disability	_____	_____
Supplemental AD&D	_____	_____	Long Term Disability	_____	_____
Dependent Life	_____	_____	Voluntary LTD	_____	_____

If the employee pays for any portion of this premium, please answer the following:

- a) Premium will be collected on a Pre-tax basis Post-tax basis
- b) Total number of eligible employees _____ Total number of participating employees _____

Statutory Coverage Information

Are there any employees working in these cash sickness states?

If yes, please indicate on the final census.

- | | | |
|-----------------------------|------------------------------|--------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | California |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hawaii |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | New Jersey |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | New York |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | Rhode Island |

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Sold Rates

Basic Life	_____	Voluntary Life	_____
Basic AD&D	_____	Voluntary AD&D	_____
Supplemental Life	_____	Short Term Disability	_____
Supplemental AD&D	_____	Long Term Disability	_____
Dependent Life	_____	Voluntary LTD	_____

If any rates sold are step-rated, please attach a separate sheet detailing the rates by age band.

Booklets

Shipping (select one): Policyholder Agent

If more than one class, do you want separate booklets for each class? No Yes

If more than one line of coverage, do you want separate booklets for each line? No Yes

Would you like a Summary Plan Description included in your booklet? No Yes

If yes, please provide us with the following information. What is the Plan Number for each line of coverage sold?

Life _____ AD&D _____ STD _____ LTD _____ Other _____

How are plan records kept? Calendar Year Fiscal Year Plan Year

Fiscal records begin: _____
Plan Year begins (if different from Eff. Date) _____

Family Medical Leave (not available on Short Term Disability)

Do you want to continue coverage for employees who are on leave of absence as defined by the Family and Medical Leave Act of 1993? No Yes

If yes, premium must be paid during an employee's leave for coverage to remain in force.

Administration

Will there be multiple bill groups? No Yes

If yes, provide us with the name, address, correspondent and phone number for each additional billing location.

Type of Billing Self Administered Third Party Administered _____

If we insure your Long Term and Short Term Disability, would you like us to prepare your W-2's? No Yes

To Be Completed by Licensed Agent

Name of Licensed Agent/Agency to receive commission _____

If individual, provide SSN _____ If corporate, provide tax ID number _____

Address _____

Contact Person _____ Phone _____ Fax _____

E-Mail Address _____ Are you currently licensed with FRSLIC? No Yes

Form completed by: _____ Title: _____

Signature _____ Date: _____