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

# Hospital Indemnity Continuation Request

This form is to be used only when a person desires and is eligible to continue Hospital Indemnity Insurance.  This form must be completed in full and submitted to The Company within 60 days following the date of termination of insurance coverage.  SEND TO:  Reliance Standard Life In surance 55 Company, Premium Billing and Collection, 2001 Market Street, Suite 1500 , Philadelphia, PA  19103-7090.  Email: portates@rsli.com. Fax number: 800-680-6760.

**VERIFICATION OF INSURED PERSON'S ELIGIBILITY TO CONTINUE HOSPITAL INDEMNITY**

<u>To Be Completed By Policyholder/Participating Unit</u>

☐ Male ☐ Female

1.  Insured Person's full name_____  2. Soc. Sec. Number_____
(Please Print)

3.  Name of Policyholder/Participating Unit _____4. Policyholder/Participating Unit No.: _____

5.  Branch or Location (if different from 3.) _____

6.  Date of Hire:_____     Class: _____

7.  Effective Date of Coverage:  Employee:_____     Spouse, if any:_____ Children, if any:_____

8.  Date Person Last Worked _____

9. Date Coverage Terminated (if different from 8.) _____

10.  If ( 8) and ( 9) differ, please explain _____

11.  Plan and Coverage in force, applicable to this Insured, under the Policy on date of termination of insurance coverage:
     Plan: ☐ Voluntary Hospital Indemnity

   Coverage:  ☐ Employee Only ☐ Employee & Spouse  ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

12.Verified by _____
(Signed by authorized individual)                     Date                            Phone Number

---

<u>To Be Completed By Applicant</u>

Name _____          Spouse's Name _____

Date of Birth: Employee_____ Date of Birth: Spouse_____ Date of Birth Children, if any _____

Address _____
(Street)                                          (City)                    (State)           (Zip)

Coverage Desired:  ☐ Employee Only   ☐ Employee & Spouse  ☐ Employee & Child(ren)
                   ☐ Employee, Spouse & Child(ren)

Plan and Coverage elected to be continued **may not exceed Plan and Coverage option in force,** applicable to this Insured, under the Policy on date of   termination of insurance coverage

Beneficiary:

| Full Name(s) | Relationship | Percent of Proceeds | SSN |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| Signature of Applicant | Email Address | Phone Number | Date Signed |