RELIANCE STANDARD LIFE INSURANCE COMPANY
Home Office: 1900 East Golf Rd
Suite 500
Schaumburg IL, 60173.

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov online** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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Enrollment / Life Event Change Form

Section A: Instructions

- ✓ **REVIEW PLAN INFORMATION** - The enrollment materials that you received contain important information about the benefits, costs, exclusions & limitations of the plans. Please review the enrollment materials carefully and decide which options are best for you and your family.
- ✓ **YOU MUST COMPLETE SECTION B AND C.**
- ✓ **SELECT COVERAGE IN SECTION D** - Refer to the table below for the costs of the plans. Decide which plans you want to enroll in and who you would like to cover.
- ✓ **COMPLETE SECTION E** only if you would like to enroll your eligible dependents.
- ✓ Eligible employees may only enroll during the **Open Enrollment Period**. Newly hired employees have 31 days to enroll after the date they become eligible.
- ✓ **QUALIFYING LIFE EVENT** - There may be events that will allow you to enroll yourself and your eligible dependents outside of the Open Enrollment Period. Complete **Section G** if you've experienced a Qualifying Life Event outside of an Open Enrollment Period.
- ✓ It is important that you follow these directions when making your elections; otherwise, your enrollment/elections may be delayed.
- ✓ **Make sure to sign and date this form in Section H and keep a copy of your completed form for your records.**

Section B: Reason for Enrollment/Change (Select only ONE)

☐ Open Enrollment	☐ New Hire	☐ Qualifying Life Event	☐ Address Change Only

Section C: Information About You (Print neatly within the boxes)

EMPLOYER NAME: VILLA RESTAURANT GROUP			LOCATION CODE:
YOUR NAME (FIRST, MIDDLE, LAST):			
SOCIAL SECURITY NUMBER:	DATE OF BIRTH (MM/DD/YYYY):	GENDER (M, F, OTHER):	
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME/CELL PHONE NUMBER:	EMAIL ADDRESS:		

Section D: Enrollment Selection

Make your selection by putting an "**X**" in the box next to the selection you want. You must mark a box in each part. **Costs listed below are Weekly amounts.**

MEDICAL SELECTION	BasicAdvantage Total (BAT)[1], Essential (EP)[2] & Dental Plan
Employee Only	☐ $19.64
Employee + Spouse	☐ $48.24
Employee + One Child	☐ $42.40
Employee + Children	☐ $63.74
Employee + Family	☐ $68.89
DECLINE COVERAGE	☐

[1] The costs shown include an administrative fee which is in addition to the plan's premium.
[2] The costs shown may include amounts paid for Affordable Care Act taxes and fees that are in addition to the Essential plan's premium.

Section E: Information About Your Enrolling Dependents[3,4] (Print neatly within the boxes)

Name (First, Middle, Last)	Relationship	Date of Birth (MM/DD/YYYY)	SSN	Gender (M, F, Other)

[3] Eligible children must be under the age of 26, unless disabled..
[4] If you have a dependent child not living with you, please provide their address in Section F on the back of this form.

(OVER PLEASE)

Section F: Addresses of Dependents not Living with You (Print neatly within the boxes)

Name (First, Middle, Last)	Street Address	City	State	Zip Code

Section G: Qualifying Life Event[5] (Please mark an "X")

COMPLETE THIS SECTION ONLY IF YOU HAVE EXPERIENCED A QUALIFYING LIFE EVENT outside of an open enrollment period and need to elect or make a change because of a qualifying life event. Do NOT complete this section if you are a new hire looking to enroll for the first time in the program.

☐ Address Change Only	☐ Birth or Adoption of Child
☐ Marriage	☐ Child Eligible (Foster Child / Court Order)
☐ Divorce/ Legal Separation	☐ Child Now Ineligible (Child Reaching Limiting Age)
☐ Death of Dependent	☐ Loss of Other Health Coverage
☐ Other (Please describe):	
DATE OF LIFE EVENT (MM/DD/YYYY):	

[5] If you fail to provide notification within 31 days of a qualified life event, you may not be able to enroll yourself or your dependents, or change your current elections unless there is an Open Enrollment Period.

Section H: Declaration & Authorization (Keep a copy of this completed form for your records)

I hereby declare that the information I provided on this form is accurate and complete. I wish to participate in the benefit plan(s) that I've selected in Section D and I authorize my employer to deduct the necessary contributions from my paycheck.

Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to criminal and punitive proceedings.

YOUR SIGNATURE:	**DATE (MM/DD/YYYY):**

All plans are underwritten by:

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LIFE INSURANCE COMPANY