Standard Insurance Company

Continued Benefits
800.378.4668 Tel 800.331.3397 Fax
920 SW Sixth Avenue Portland OR 97204

STANDARD VOLUNTARY INSURANCE
APPLICATION TO CONTINUE GROUP LIFE INSURANCE AND DEPENDENTS LIFE INSURANCE (PORTABILITY)

INSTRUCTIONS — PLEASE READ CAREFULLY

Continuation Of Insurance

You may continue your Group Life Insurance and Dependents Life Insurance if your employment with your employer terminates. However, to be eligible to continue your Group Life Insurance and Dependents Life Insurance, you must meet the following requirements on the date your employment terminates:

1. You are not Totally Disabled.

If you do not continue your Group Life Insurance, you may not continue your Dependents Life Insurance.

How To Apply

You must apply in writing and pay the first premium to us within 31 days after the date your employment terminates. Your application packet has two forms: one for you and one for the employer. All questions on these forms must be completed. If you have questions while completing your application, please contact our office at the phone number shown above. You are responsible for making sure all required forms are completed and returned to our office. Processing of your application will begin when both completed forms are received by us.

The amount you may continue is the amount in effect on the date your employment terminates.* You may continue any lesser amount for you or your Spouse, in multiples of $10,000. The amount continued for your Spouse may not exceed the amount you continue for yourself. For your Child, you may continue any lesser amount shown in the Schedule of Dependents Life Insurance in your certificate. The amount continued will be reduced or terminated according to the Schedule of Insurance in effect on the date your employment terminates. You may not increase the amount you continue.

* Any combination of insurance you continue and insurance you convert may not exceed the amount for which you or your dependents were insured on the date your employment terminates.

The initial premium rate will be the rate in effect on the date your employment terminates, and an administrative fee will be added. If it is necessary to change premium rates in the future, you will be given advance notice of the change. You will be billed at your home address. Checks are to be payable to Standard Insurance Company.

Keep your certificate. It is your certificate of coverage for your continued insurance. Your continued insurance is subject to the terms of the Group Policy.

Beneficiary Designation

Please provide us with the beneficiary designation form on file with your employer. If you cannot provide that form or it you wish to change your beneficiary designation, please complete the Beneficiary section of the attached application. If we do not receive the form and if you do not complete the Beneficiary section of the attached application, you will not have a designated beneficiary. In that event, payment of any benefit will be made in accordance with the Beneficiary Provisions of the Group Policy.

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STANDARD VOLUNTARY INSURANCE APPLICATION TO CONTINUE GROUP LIFE INSURANCE AND DEPENDENTS LIFE INSURANCE (PORTABILITY)

Please type or print. Complete entire form.

IDENTIFICATION

Name: _____
(last) (first) (middle)

Address: _____
(street address)

_____
(city) (state) (zip code)

Social Security Number: _____ Telephone No. ( ) _____

Birthdate: _____ Sex ☐ M ☐ F
(mo) (day) (year)

GROUP POLICY

Name of Participating Employer: _____

Your occupation with the Participating Employer: _____

• Date you last worked for the Participating Employer: ____ / ____ / ____

• Employment termination date (if different): ____ / ____ / ____

If date you last worked and employment termination date differ, please explain: _____

_____

ELIGIBILITY

Are you Totally Disabled? ☐ Yes ☐ No

If yes, you may be entitled to Waiver Of Premium Benefits if you became Totally Disabled while insured under the Group Policy. Check the following box to request Waiver Of Premium claim forms from Standard Insurance Company. ☐

AMOUNT

Amount of Group Life Insurance you wish to continue for yourself (must be in multiples of $10,000, not to exceed the amount in effect on the date your employment terminates): $ _____

Amount of Dependents Life Insurance you wish to continue for your Dependents (must be in multiples of $10,000; the spouse amount cannot exceed the amount of your continued Group Life Insurance):

Spouse $ _____ Each Child $ _____

Any combination of insurance you continue and insurance you convert may not exceed the amount for which you or your dependents were insured on the date your employment terminates.

Spouse's birthdate: ____ / ____ / ____

Dependent Child(ren) birthdate: ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____

Billing: If approved, you will be billed quarterly (every three months), at your home address. There is an administration fee associated with your continued insurance. Premiums must be received by the due date. There is no grace period for Continuation Of Insurance.

Please complete reverse side *(continued)*

BENEFICIARY

Full name of your beneficiary:

_____ Relationship _____

Address _____

_____

I understand that this designation supersedes any previous beneficiary designation made with respect to my Standard Voluntary Insurance Trust Group Life Insurance.

Signature _____ Date _____

AGREEMENT

I hereby apply to continue Group Life Insurance available through the Standard Voluntary Insurance Trust. I understand that I am bound by the terms of the Standard Voluntary Insurance Trust Agreement and any amendments to it.

I agree that no coverage will take effect until it is approved in writing by Standard Insurance Company. I understand that if this application is not accepted, any premium advanced by me will be refunded.

I understand that if I do not provide the beneficiary designation form on file with my employer or if I do not designate a beneficiary in the Beneficiary section above, payment of any benefit will be made in accordance with the Beneficiary Provisions of the Group Policy.

I hereby represent that all statements on this application are complete and true to the best of my knowledge and belief. I understand that Standard Insurance Company will rely on these statements and this information, along with the Employer's Statement for continued Group Life Insurance, as the basis for approving this application. I have read and understand the information herein.

Signature of Applicant: _____

Dated _____

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STANDARD VOLUNTARY INSURANCE
PARTICIPATING EMPLOYER'S STATEMENT FOR CONTINUATION OF GROUP LIFE INSURANCE (PORTABILITY)

Please type or print. Complete entire form.

Employee's Full Name: _____ ☐ Male ☐ Female

Employee's Social Security Number:_____ Birthdate:_____

Employee's Occupation: _____

Employee's Mailing Address: _____ City: _____ ST:____ ZIP:_____

Participating Employer Name: _____

Participating Employer Number: _____ Effective Date of Employer Participation: _____

Is the employee's Group Life Insurance ending because of employment termination? ☐ Yes ☐ No

If yes, date of employment termination:_____/____/_____ Date coverage ends:_____/_____/_____

Date employee last worked:_____/_____/_____

If no, reason for termination of employee's Group Life Insurance: _____

_____

Original effective date of coverage:

Employee_____/_____/_____ Spouse_____/_____/_____

Children_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

Is the employee Totally Disabled? ☐ Yes ☐ No

Amount of Group Life Insurance in effect on the date of employment termination:

Employee $_____ Spouse $_____ Each Child $_____

PLEASE ATTACH ORIGINAL LIFE ENROLLMENT CARD OR FORM.

I hereby represent that the above information is true and complete to the best of my knowledge.

_____ _____
Date Signature of Participating Employer's Representative

_____ _____
Telephone Number Title

_____
Address