

## INSTRUCTIONS – PLEASE READ CAREFULLY

### **Portability Of Insurance**

You may be eligible to buy portable Group Life Insurance if your employment with your employer terminates. If your employer's Group Life Insurance plan includes Accidental Death and Dismemberment (AD&D) and/or Dependents Insurance, you may also be eligible to buy those coverages. If you do not buy Life Insurance for yourself, you may not purchase any other insurance coverages.

The minimum and maximum amounts of insurance eligible for Portability Of Insurance are shown in your employer's Group Life Insurance plan. The amounts of insurance you purchase under the Portability Of Insurance provision cannot be increased.

NOTE: Refer to the Right To Convert provision in your employer's Group Life Insurance plan for information regarding eligibility to convert to an individual life insurance policy. The combined amounts of insurance you purchase under the Portability Of Insurance provision and insurance you convert may not exceed the amount for which you or your Dependents were insured on the day before your employment terminates. You may also wish to contact an independent insurance agent to discuss other alternatives.

### **How to Apply**

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

Premium rates are shown on Page 2 of this application, and are subject to increase with advancing age. Premium rates may be changed by Standard Insurance Company with advance written notice. Approved applicants will be billed quarterly (every three months). Checks are to be payable to Standard Insurance Company. Premium must be received by the due date.

If your application is approved, you will receive a Group Life Portability Insurance certificate which will provide a complete description of coverage. The Group Life Portability Insurance certificate will contain provisions that will be different from your employer's Group Life Insurance plan.

Please note:

Approved amounts will be reduced or terminated according to the terms of the Group Life Portability Insurance Policy.

Group Life Portability Insurance ends automatically on the earliest of:

1. The date it would otherwise end under the Group Life Portability Insurance Policy.
2. The date the last period ends for which we received the required payment.
3. The date the Group Life Portability Insurance Policy terminates.
4. The date you become a full-time member of the armed forces of any country.
5. For any AD&D Insurance, the date your Life Insurance ends.
6. For any Spouse Insurance, the date of your divorce or legal separation.
7. For any Dependents Insurance:
  - a. The date your portable Life Insurance ends.
  - b. The date the Dependent ceases to be a Dependent.

### **Beneficiary Designation**

**Beneficiary designations that you made under your employer's Group Life Insurance plan will not apply to Group Life Portability Insurance.** If you wish to designate a beneficiary for Group Life Portability Insurance, please complete the Beneficiary section on Page 4. If you do not designate a beneficiary, payment of any benefit will be made in accordance with the Benefit Payment and Beneficiary Provisions of the Group Life Portability Insurance Policy.

**GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE**

<b>Monthly Premium Rates for Member &amp; Spouse per \$1,000 of Insurance</b>			
<b>Age</b> (on last birthday)	<b>Non-Tobacco Rate</b>	<b>Tobacco Rate</b>	
0-34	\$ 0.16	\$ 0.22	
35-39	0.17	0.24	
40-44	0.23	0.34	
45-49	0.39	0.56	
50-54	0.56	0.81	
55-59	0.97	1.38	
60-64	1.47	2.09	
65-69	2.87	3.98	
70-74	4.70	6.31	
75-79	6.99	9.05	
80+	12.82	16.00	

  

	Member	Spouse	Child
1. Age			
2. Monthly Rate for age from above table			\$0.16 per \$1,000
3. Amount of Insurance			
4. Divide Line 3 by 1,000			
5. Multiply Line 4 by Line 2			
6. Add all amounts in Line 5 to arrive at Monthly Premium Amount: \$			

**GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (if applicable)**

Monthly Premium Rate for Member is \$0.04 per \$1,000 of AD&D Insurance.	Member
a. Total amount of Insurance from Line 3 above	
b. Divide Line a by \$1,000	
c. Multiply Line b by \$0.04 to arrive at Monthly Premium Amount: \$	

**TOTAL PREMIUM**

1. Add the total Life premium amount (Line 6) to the total AD&D amount (Line c), if applicable to determine monthly premium.	\$
2. Multiply by 3 months to determine the Total Quarterly Premium Due.	\$ <b>TOTAL QUARTERLY PREMIUM DUE</b>

NOTE: Please make checks out to Standard Insurance Company and submit the first premium payment to your employer. All other premium payments should be remitted directly to Standard Insurance Company (Attn: Continued Benefits, 920 SW Sixth Avenue, Portland, OR 97204).

*Please type or print. Complete entire form.*

**1. MEMBER INFORMATION**

Name: (last, first, middle)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address:	City:	State:	Zip Code:
Social Security No.:	Telephone No.:	Birthdate: (month, day, year)	

**2. DEPENDENTS INFORMATION (if applicable)**

Spouse Name: (last, first, middle)	Spouse Birthdate: (month, day, year)
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**3. EMPLOYER INFORMATION**

Name of Group:	Name of Employer: (if different)
Group No.:	Your occupation with the Employer:
Date you last worked for the Employer:	Employment termination date: (if different)
If date you last worked and employment termination date differ, please explain:	

**4. ELIGIBILITY**

Date you became insured under your Employer's coverage under the Group Policy:
Have you or your spouse used tobacco in any form in the last 12 months?    Member: <input type="checkbox"/> Yes <input type="checkbox"/> No    Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

**5. AMOUNT OF INSURANCE**

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE		AD&D INSURANCE (if applicable)
Member:	\$	\$
Spouse:	\$	\$
Children:	\$	

**Billing:** If approved, and after the first premium has been received, you will be billed quarterly (every three months), at your home address. Premium must be received by the due date.

*(continued)*

**6. BENEFICIARY**

This beneficiary designation applies to all of your Group Life Portability Insurance and Accidental Death and Dismemberment Insurance, if any.

If you name two or more beneficiaries in a class (primary or contingent): (1) Two or more surviving beneficiaries will share equally, unless you provide for unequal shares. (2) If you provide for unequal shares in a class, and two or more beneficiaries in that class survive, we will pay each surviving beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased beneficiary(ies) to the surviving beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving beneficiary bears to the total shares of all surviving beneficiaries. (3) If only one beneficiary in a class survives, we will pay the total death benefits to that beneficiary.

If no beneficiary (primary or contingent) survives you, payment will be made as provided in the Group Life Portability Insurance Policy.

Insurance on your Spouse or other Dependents, if any, is payable to you, if living, or as provided under the terms of the Group Life Portability Insurance Policy.

**Note:** If death occurs and a minor is the beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid.

**Primary**

Full Name:	% of Benefit:	Address:
Social Security No.: <i>(if known)</i>	Date of Birth:	Relationship
Full Name:	% of Benefit:	Address:
Social Security No.: <i>(if known)</i>	Date of Birth:	Relationship

**Contingent**

Full Name:	% of Benefit:	Address:
Social Security No.: <i>(if known)</i>	Date of Birth:	Relationship
Full Name:	% of Benefit:	Address:
Social Security No.: <i>(if known)</i>	Date of Birth:	Relationship

*(continued)*

**7. AGREEMENT**

I hereby apply for Group Life Portability Insurance.

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

I understand that if I do not designate a beneficiary in the Beneficiary section on page 4, payment of any benefit will be made in accordance with the Benefit Payment and Beneficiary Provisions of the Group Life Portability Insurance Policy.

I hereby represent that all statements contained herein are complete and true to the best of my knowledge and belief, and that I meet all eligibility requirements. I have read and understand the information herein, including the applicable Fraud Notice below.

**FRAUD NOTICES**

**FOR RESIDENTS OF ARKANSAS, DISTRICT OF COLUMBIA, KENTUCKY, LOUISIANA, MAINE, NEW MEXICO, OHIO AND TENNESSEE:** Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

**FOR RESIDENTS OF COLORADO:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FOR RESIDENTS OF FLORIDA:** Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**FOR RESIDENTS OF NEW YORK:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**FOR RESIDENTS OF PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature:

Date:

*Please type or print. Complete entire form. To be completed by Employer.*

**1. MEMBER INFORMATION**

Full Name:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number:	Birthdate:	Occupation:

**2. EMPLOYER INFORMATION**

Group Name:	Employer Name: (if different)
Group No.:	Effective date of Employer's coverage under the Group Policy:
Is the Member's Group Life Insurance ending because of employment termination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of employment termination:	Date coverage ends:
Date Member last worked:	
If no, reason for termination of Member's Group Life Insurance:	
Original effective date of Member's coverage:	

**3. AMOUNT OF INSURANCE**

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE		AD&D INSURANCE (if applicable)
Member:	\$	\$
Spouse:	\$	\$
Children:	\$	

**4. EMPLOYER AUTHORIZATION**

I hereby represent that the above information is true and complete to the best of my knowledge. In addition, I acknowledge I have read the Fraud Notice on the next page.	
Signature of Authorized Representative:	Date:
Name and Title: (please print or type)	
Address:	Telephone No.:

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