



TheStandard®
Positively different.

Administration Guide for District Paid Group Insurance Plans Endorsed by CTA

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

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Using This Guide

This guide is designed to help you administer your District Paid Group Insurance provided by Standard Insurance Company (The Standard) and endorsed by California Teachers Association (CTA). It contains information about your District Paid plan features and provisions within The Standard's plans. References to policy terms and provisions are indicated by an initial cap. References to policy terminology and provisions are indicated by an initial cap. (That is, the first letter of the word is capitalized; however, some non-policy terms also have an initial cap.) To find these terms defined in your Certificate of Insurance, see the Certificate's Index of Defined Terms or its table of contents. The information here does not amend, alter or waive any provision in your coverage under the Group Policy (ies) issued by The Standard. In the event of a conflict between this guide and the Group Policy(ies), the terms and conditions of the Group Policy(ies) govern.

About The Standard's Forms

Forms, which are referred to by name here, are listed in Appendix A. To avoid errors, we strongly encourage you to use The Standard's forms, which are available at www.standard.com/cta. However, if you are unable to access the forms, call The Standard's CTA Call Center at 1-800-522-0406. If your own form has been approved by The Standard for use, you may continue using it.

About the Various Plans

Some District Paid plans provide Life Insurance, some provide Disability Insurance, and some provide both. Although this guide is for both plans, see your Certificate(s) of Insurance and Summary Plan Description (SPD) for the details of your plans, and disregard any information that does not apply to your district. Some District Paid plans are closed plans, which means that you cannot enroll new Participants in them. Review the relevant Certificate/SPD for information about administering these plans.

When You Have Questions

The Standard is pleased to assist you in your role as administrator. For questions not answered by this guide or your Certificate, contact us directly at The Standard's CTA Call Center, 1-800-522-0406.

Questions? Call 1-800-522-0406

Welcome to The Standard

Your role as administrator is crucial to ensuring that the Participants insured under the various plans have the right expectations and the right outcomes should a loss occur. Our role at The Standard is to process and review claims and make claims decisions when covered losses occur. Our staff is available to support you in your role so you can do the very best job for your Participants—and do it with ease.

Our goal is to streamline the plan administration process with timely information and resources, and our support takes many forms. We provide materials such as this guide. Our online tools are intended to make your job easier. If you haven't already browsed them, we invite you to do so. But most importantly, our people are here to help you—we have a team dedicated to your needs as the administrator. If you haven't already spoken with one of our Customer Experience Specialists, please do when that first question arises.

We at The Standard have a long history of providing Group Insurance services, particularly in the public and education sectors. We have drawn on our experience to provide the structure to support you.

Your Responsibilities as an Administrator

As administrator of your Group Insurance plan, you are responsible for these tasks, which are essential to ensuring accurate and timely administration. We value your help, and we're here to support your efforts. Review your Certificate and this guide carefully to understand the policy terms and all the tasks required in administering your plans. Your responsibilities include the following types of activities, which are explained in detail in this guide:

- Eligibility and Enrollment
- Changes, Terminations, and Reinstatements
- Certificates and Notices
- Billing Administration
- Claims Submission

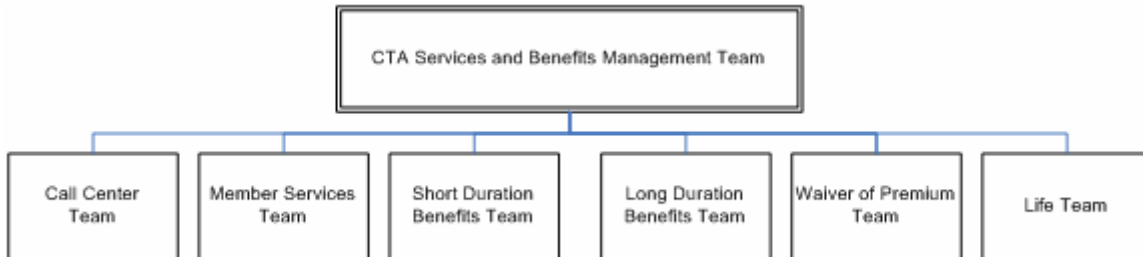
Note: If your district has a Self-Administered plan, see Appendix B.

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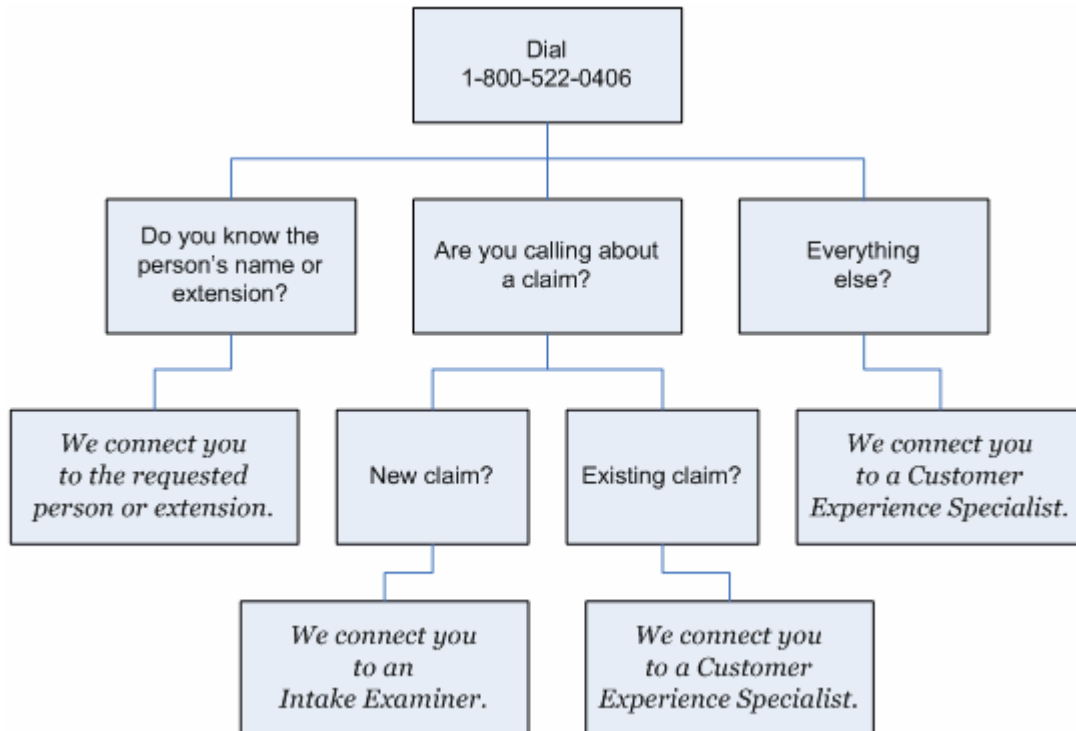
The Standard Is Organized To Support You

The Standard created a business unit dedicated to support CTA-endorsed insurance plans and streamline the administrative process.



Call 1-800-522-0406 With Your Questions

Beginning on September 1, 2007, The Standard's CTA Call Center will be answering your calls from 7 a.m. to 7 p.m. Pacific Time, Monday through Friday. The Standard's phone system will ask only a few, basic questions so that we can connect you with the right person as quickly as possible.



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Contact The Standard Electronically

Via e-mail, send The Standard a message to ctaadmin@standard.com any time and receive an answer by the next business day.

Via the Internet, visit The Standard's CTA-dedicated site at www.standard.com/cta.

Contact The Standard by Mail

Payments Only: Standard Insurance Company CB, PO Box 4664,
Portland, OR 97208-4664

Claims-Related Issues: Standard Insurance Company,
PO Box 2773, Portland, OR 97208

Enrollment and Billing Issues: Standard Insurance Company
PO Box 4744, Portland, OR 97208

AdminEASE: An Online Tool for Your Convenience

Beginning September 1, 2007, you can access The Standard's online tool, AdminEASE, to do the following:

- view a summary of your bill online
- view and download a list of insured Participants
- view evidence reports
- view claim reports
- access and complete Employer portions of forms

Signing Up for AdminEASE

To access this tool, go to www.standard.com/cta and click the link to sign up for AdminEASE.

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Eligibility and Enrollment

Summary of Responsibilities

- Determine when Participants are eligible for insurance coverage.
- Verify that Participants meet applicable requirements to become insured.
- Enroll Participants for coverage.
- Assist Participants in submitting required applications.
- Notify The Standard of new enrollees by sending a copy of the enrollment form.
- Maintain related plan records.

For District Paid plans, the school districts typically retain copies of the basic, District Paid enrollment forms and Beneficiary Designation forms. However, if your district has arranged for The Standard to retain this material for you, your responsibilities will include submitting these forms.

Determining Eligibility and Effective Dates

To become insured, Participants must

- satisfy the Definition of Participant
- satisfy requirements for Active Work
- satisfy Evidence Of Insurability requirements (if applicable) and
- pay their premiums (if applicable) or have their premiums paid by the school district

As you read your Certificate to determine any applicable eligibility and effective date requirements for a Participant, (1) make sure the employee satisfies the Definition of Participant, including working at least the stated number of hours per week, and (2) determine the effective date of coverage.

The Certificate details when Evidence Of Insurability (EOI) is required and when it is waived. If EOI is required, see the section titled “About Evidence of Insurability” in these guidelines.

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Questions? Call 1-800-522-0406

Verifying Active Work

Confirm that each Participant satisfies the Active Work Requirement, as defined in your Certificate. Your Certificate also explains

- how the Active Work Requirement applies to Participants who are absent or not scheduled to work on the date their Insurance is scheduled to become effective, and
- how the Active Work Requirement relates to insurance increases.

When Coverage Begins

Employer-Paid Coverage

New Participants who satisfy the Active Work Requirement have their coverage become effective on the date they become eligible.

Participant-Paid Coverage

The following information **applies to Supplemental Life Insurance, Supplemental Plus Life Insurance, and Dependents Life Insurance**. For coverage to become effective, active Participants must

- apply in writing
- satisfy the Active Work Requirement (This requirement does not apply to retirees.)
- satisfy Evidence Of Insurability requirements
- pay required premium

After Participants meet these criteria, their coverage begins on the later of these two dates:

- The first day of the calendar month coinciding with (or following) the date that new Participants apply, provided that the required premium payment is made for that month.

or

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- The first of the calendar month following the date their Evidence Of Insurability (EOI) is approved, if EOI is required, provided that the required premium payment is made for that month.

About Payroll Deductions for Dependent Coverage

Start payroll deductions for Participant-paid coverage when you receive notification from The Standard that coverage is effective. (See your Certificate for detailed information about becoming insured for Supplemental coverages and Dependents coverages.)

Enrolling Participants

The Standard's enrollment form has sections for enrolling Participants in both non-contributory and contributory coverages, designating beneficiaries, and authorizing payroll deductions.

- 1 Explain your Group Insurance plan to all new Participants.
- 2 Have Participants complete, sign, and date the enrollment form, including the Beneficiary designation section.
Note: Beneficiary designations are also used for Disability Insurance (the Survivors Benefit).
- 3 Have Participants authorize a payroll deduction if they are responsible for paying any portion of premium.
 - They must also enroll in the contributory portions of the plan and indicate any optional plan they choose.
 - Both requirements can be fulfilled by completing, signing and dating the Standard's form.
- 4 Provide each insured Participant a Certificate as instructed in the section titled "Certificates and Notices" in this guide.
- 5 Report changes and update billing, as instructed in the section titled "Billing Administration" in this guide.

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Questions? Call 1-800-522-0406

Completing the Forms

- 1 Review each form to be sure it is fully completed, including signature and date.
- 2 Retain the completed forms for your records. (If your district has arranged with The Standard to retain these forms, send the forms to us.)

Providing Coverage for the Dependents of Participants

Employer-Paid Dependents' coverage begins on the date the Participant becomes eligible, subject to the Active Work Provisions.

Participants may have Dependents who are eligible for Participant-paid coverage.

Participant-Paid Coverage

To apply for Participant-Paid Dependents coverage, Participants must

- submit an application for the Dependents coverage
- pay required premium
- satisfy Evidence Of Insurability requirements

The eligible Dependents of Participants typically have their insurance become effective on the latest of the following dates:

- the first day of the month following the date the Participant applies for Dependents Insurance
- the date the Dependent's Evidence Of Insurability is approved, if this is a requirement
- the date the Participant becomes covered for Life Insurance
- the date the Participant first acquires a Dependent

About Payroll Deductions for Participant-Paid Dependent Coverage

Start payroll deductions for Participant-paid Dependent's coverage when coverage becomes effective. (See your Certificate for detailed information about Supplemental coverages and Dependents coverages.)

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Questions? Call 1-800-522-0406

Designating a Beneficiary

About Beneficiary Designations

Insured Participants may designate one or several individuals as the Beneficiary (or Beneficiaries) for Survivors Benefit, Life Insurance, or Accidental Death and Dismemberment Insurance. In the absence of a named Beneficiary and for Dependents Life Insurance, provisions in the Certificate determine who will be entitled to the proceeds. (See your Certificate for details.)

Advise your Participants that in the following circumstances, processing delays may result or the Beneficiary may incur legal expenses (such as having to hire a conservator):

- the Beneficiary Designation form is not properly completed
- the designated Beneficiary is a minor (not of legal age)
- the designated Beneficiary is an estate
- the designated Beneficiary is a legally incompetent person.

Naming or Changing a Beneficiary

Important: Never attempt to make a change by altering an existing designation. Instead, ask the Participant to complete a new form.

- 1 Instruct the Participant to complete, sign and date The Standard's Beneficiary form.
- 2 Advise the Participant to review the Beneficiary Information section of the form
- 3 Retain the completed forms for your records.

Note: If your district has arranged with The Standard to retain these forms, then send the forms to us.

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Questions? Call 1-800-522-0406

About Evidence Of Insurability

Your Certificate may include Evidence Of Insurability requirements to obtain initial coverage, add or increase coverage or amounts, enroll late, or reinstate coverage. Medical information may be requested from the applicant and from one or more physicians or clinics. Additionally, the applicant may be required to submit to a physical exam, which may include a urinalysis and blood sample. Delays in processing request for increased coverage may result if all requested information is not submitted in a timely manner.

When an Evidence Of Insurability requirement applies, the amount of coverage subject to medical underwriting is not in force until an application (called a Medical History Statement) is approved in writing by The Standard. Our review of the application may require up to several weeks.

Keep in mind that all insurance subject to Evidence Of Insurability is also subject to your Certificate's Active Work provisions before the coverage becomes effective.

When Evidence of Insurability Is Required

Evidence Of Insurability is required for the following coverages:

- Supplemental Life Insurance
- Supplemental Plus Life Insurance

Evidence Of Insurability is also required under the following circumstances:

- for reinstatement
- for Contributory Dependents Life Insurance if application is not made within 120 days of becoming eligible for dependents coverage
- for Contributory Dependents Life Insurance if required premium contribution is not made by the third month following the date of application
- for any amount greater than the amount for which the Participant or Dependent was insured under the Prior Plan

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- for any increase in Supplemental Life Insurance, Supplemental Plus Life Insurance, or Dependents Life Insurance

See the Certificate of Insurance for exceptions to Evidence Of Insurability Requirements due to Family Status Change.

How EOI Affects Plan Administration

Read your Certificate to verify when Evidence Of Insurability is required. See also the section of these guidelines titled “Submitting for Evidence Approval” and “Notice of Approval or Declination.”

- Assist Participants in submitting Evidence Of Insurability in accordance with the terms of the Certificate.
- Closely monitor changes in amounts of insurance for all insured Participants.

Submitting Evidence of Insurability

The Standard’s Medical History Statement is the only form to be used to provide Evidence Of Insurability. However, if the applicant resides outside of California, call 1-800-522-0406 for the appropriate form.

- 1 Provide the eligible applicant a Medical History Statement, or instruct the applicant to download the form from www.standard.com/cta.
- 2 Explain to the Participant that the form must be completed in its entirety, signed and dated to avoid processing delays.
- 3 Instruct the applicant to mail the completed form to The Standard.

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Questions? Call 1-800-522-0406

Effective Date of Coverage Subject to Evidence of Insurability

Increased amounts of coverage subject to Evidence Of Insurability are not effective until the first of the month after approval by The Standard **and** the Active Work requirement has been met.

Until you receive formal notification of approval and the Active Work requirement has been met, do not submit premiums or deduct premiums for the amount of insurance coverage that is subject to Evidence of Insurability approval.

Note: If an application for an increased amount is declined, the declination will have no effect on the amount of coverage already in force.

About Notice of Approval or Declination

After coverage is approved or declined, The Standard will provide both the applicant and you with written notification.

When You Receive Notice of Approval

After receiving an Approval Notice from Medical Underwriting, begin paying premiums based on the coverage effective date.

When You Receive Notice of Denial

If coverage is declined, The Standard will notify the applicant directly regarding the specific reason for denial and provide a name and number to call with any questions. Due to privacy concerns, you will be notified only that coverage has been declined.

Questions? Call 1-800-522-0406

Changes, Terminations and Reinstatements

Summary of Responsibilities

- Communicate changes and assist Participants in completing related forms.
- Determine when insurance terminates and provide the conversion or portability letter, as appropriate.
- Notify The Standard of Participant changes that affect billing using the appropriate form: (a) Billing Change Form for salary and terminations, or (b) enrollment form for new additions, or (c) the Participant Change Form for other changes.

Changing Participant Status or Family Status

Eligibility for insurance and amounts of coverage may change because of a change in status related to a Dependent or to the Participant's marital status. Follow these steps when a status change occurs and the Participant wants to change coverage.

- 1 Read your Certificate to determine whether changes in insurance are allowed without Evidence Of Insurability.
 - If no Evidence Of Insurability is required, instruct the Participant to complete, sign, and date the enrollment form and return it to The Standard.
 - If Evidence Of Insurability is required, instruct the Participant to complete relevant sections and to sign and date The Standard's enrollment form and Medical History Statement and return it to The Standard.
- 2 Review newly completed enrollment forms to assess whether the status changes will affect insurance coverage and any corresponding plan administration.
- 3 When a change in insurance becomes effective under the terms of the Certificate, adjust the coverage and your premiums, as appropriate, on the Premium Remittance Statement.

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Questions? Call 1-800-522-0406

About Coverage Changes at Retirement

Disability Insurance ends at retirement. However, those retirees who were covered for Life Insurance (and Dependents Life Insurance) immediately before they retired **and** who are eligible to receive State Teachers Retirement System (STRS) or Public Employees Retirement System (PERS) are also eligible for Life Insurance and Dependents Life Insurance benefits.

If retiring Participants who meet the following criteria are interested in continuing Life coverage, have them contact The Standard at 1-800-522-0406. We will then provide information about continuing coverage. Basically, retirees must

- apply within 120 days of retirement
- authorize premium deduction from STRS/PERS, and
- pay the required premium payment beginning no later than the third month following application.

Important: If retirees' insurance ends because they fail to make the required premium contribution, they may not become insured again.

How Retirement of Participants Affects Plan Administration

As the plan administrator, you need only (1) complete and submit a Billing Change form to The Standard and (2) advise the retiring Participant about possible continuation of coverage.

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Questions? Call 1-800-522-0406

Options When Insurance Reduces or Terminates

Your Certificate contains an explanation of the conditions under which insurance terminates or reduces.

- **Life Insurance:** When Life Insurance reduces or is terminated under the policy terms, the insured Participant (or the Participant's Spouse, Domestic Partner, or Dependent Child) may be able to convert to an individual Life Insurance policy and/or to purchase insurance under a Portability Of Insurance provision.
- **Disability Insurance:** When Disability coverage ends under the Group Policy, the insured Participant may be able to purchase Disability Conversion Insurance.

See your Certificate for specific information about the requirements Participants must meet to exercise these options when insurance terminates or reduces. See also the section titled "Administering Terminations and Reductions" in this guide.

About Participants With Disabilities

Participants who have disabilities may be able to continue Life and Dependents Life Insurance under Waiver Of Premium provisions. See the following sections in these guidelines and contact The Standard's CTA Call Center if you have questions.

- In the section of these guidelines titled "Benefits Administration for Group Life Insurance Benefits," see the sub-section "Waiver of Life Insurance Premium."
- In the section of these guidelines titled "Billing Administration," see the subsection titled "Premiums During Disability."

Questions? Call 1-800-522-0406

Administering Terminations and Reductions

When insurance terminates or reduces, follow these steps.

- 1 Inform the insured Participant that coverage under the Group Policy is being reduced or terminated and specify the date this change becomes effective.

Note: If the change in coverage is for a Child, a Spouse, or a Domestic Partner, you may provide this information to the family member.
- 2 Determine the type of insurance coverage that is changing:
 - For Life Insurance conversion and Portability rights, we ask that you immediately provide the insured Participants or their family members with the Notice of Right of Conversion and/or Portability letter.
 - For Disability Insurance conversion, see the following section, titled “Converting Disability Coverage.”
- 3 Stop or adjust payroll deductions if the Participant was contributing toward the cost of insurance.
- 4 Report changes and update your billing according to the instructions in the section titled “Administering Billing” in this guide.

Administering Disability Conversion

Your Disability coverage with The Standard includes a Conversion Of Insurance provision. This feature is available only to Class 2 Participants (contract educator participants having fewer than five years of STRS/PERS credited service) whose insurance is not ending due to retirement.

Note: Disability Conversion is not available to disabled Participants.

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Questions? Call 1-800-522-0406

Steps for Converting Disability Coverage

- 1 Give Participants the conversion request form to complete and send to The Standard.
- 2 Explain that upon receipt of the request, The Standard will send the Participant an Application for Long Term Disability Conversion Insurance to be completed by you and the Participant.
Note: This application and premium payment must be submitted in the time frame noted in the Certificate.
- 3 When the Participant returns the completed application to you, complete the Employer portion and send the application to The Standard with premium payment. (Or instruct the Participant to do so, after the entire application is completed.)

Reinstating Insurance Coverage

Reinstating insurance coverage may apply to Participants (1) who were formerly insured under the Group Policy and who return to work, or (2) for whom insurance ended because of a withdrawal from the insurance coverage, reduction in work hours, or other reasons.

- 1 Refer to your Certificate's Reinstatement Of Insurance provision to determine requirements.
- 2 If required, instruct the Participant to submit Evidence Of Insurability. (See "About Evidence Of Insurability" in this guide.)
- 3 Complete enrollment forms as instructed in "Enrolling New Participants" in this guide.
- 4 Report changes and adjust billing as appropriate. (See "Making Participant Adjustments" in this guide.)

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Questions? Call 1-800-522-0406

Certificates and Notices

Summary of Responsibilities

Provide Certificates of Insurance and Notices of Plan Change to all insured Participants.

Distributing Information to Insured Participants

The Standard supplies you with a Certificate of Insurance, which describes the coverage available under the master Group Policy. If the plan subsequently changes, you will receive a Notice of Plan Change.

To inform your Participants of the coverage available to them,

- Give Participants the Certificate when their insurance becomes effective. Distribute Certificates even if you also distribute Notices of Plan Change, booklets, or other material approved by The Standard.
- When The Standard issues a Notice of Plan Change (which reflects changes made by an amendment), give a notice to each insured Participant.

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Questions? Call 1-800-522-0406

Billing Administration

Summary of Responsibilities

- Submit Premium Remittance Statements and pay premiums when they are due.
- Notify The Standard of Participant changes that affect billing using the appropriate form: (a) Billing Change Form for salary and terminations, or (b) enrollment form for new additions, or (c) the Participant Change Form for other changes.
- Monitor benefit claims to assure proper coordination with billing.

About The Standard's Bills

Typically, we mail billing statements 11 days before the premium due date. These statements have two parts:

- The first pages are the Census List, which is a roster of all insured Participants and their individual premiums.
- The last page is a summary of volume and premium due by coverage.

For more information, see the [annotated bill](#) posted on our Web site (www.standard.com/cta).

About Premium Due Dates and Grace Periods

Premiums are due on the first calendar day of the period for which you are billed. (Your District may have negotiated a different pay mode.) Contact ctaadmin@standard.com for questions regarding premium due dates for negotiated pay modes.

Timely payment of premiums is required for Participants to remain covered by an insurance policy. Your Grace Period is 60 days. If premiums are not paid timely, individual Participant insurance coverage will end.

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Questions? Call 1-800-522-0406

About Volume Reports

Volume is the amount of coverage each insured Participant has, according to your Group Policy. Premiums for Life, AD&D, and Disability Insurance are based on amounts stated in the Schedule Of Insurance in your Certificate, up to a maximum benefit amount. Although The Standard calculates volume for you based on insured Participant data, it is your responsibility to provide The Standard with up-to-date information on all Participants.

General Information About Paying Premiums

- 1 Review the billing census and use your Premium Remittance Statement to calculate the premium due and to report billing changes.
- 2 Review and validate the total number of Lives and Volume (insured Participants).
- 3 Report the total Volume (benefit amount or insured earnings), according to Reporting Volume in this section of the guide.
- 4 Calculate premium figures. See the Coverage Features or Premiums section of your Certificate.
- 5 Make your check payable to Standard Insurance Company. Include your Group Policy Number and division number on your check.
- 6 Return the Premium Remittance Statement and your payment in the envelope provided.

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Making Participant Adjustments

You are responsible for reporting and making billing adjustments to reflect Participant additions, terminations, and volume increases and decreases. These are the steps for adjusting your premium.

- 1 Review the billing census and report all changes.
- 2 Adjust the amount of premium and pay the amount due.
- 3 Send your statement and your premium remittance to Standard Insurance Company CB, PO Box 4664, Portland, OR 97208-4664.

For ease of administration, premium payments and adjustments are usually calculated as of the first of the month coinciding with or following a change.

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Questions? Call 1-800-522-0406

Paying Premiums During Disability

To maintain Group Insurance coverage for Participants who are away from work because of disability, it may be necessary to continue premium payments on their behalf.

Paying Premiums for Group Life Insurance During Disability

Life Waiver Of Premium allows coverage to continue during Total Disability without payment of premium for Participants becoming Totally Disabled before age 60. Follow these steps when an insured Participant is away from work because of disability.

- 1 Instruct Participants under age 60 to submit a Life Waiver of Premium claim according to directions in the Benefits Administration for Group Life Insurance Benefits section of this guide.
Note: Participants who are age 60 or older are not eligible.
- 2 Continue paying premiums until a claim decision is made as long as the Participant remains eligible for coverage.
- 3 If premium contributions are required from your insured Participants, arrange for disabled Participants to pay their premiums to you before you submit payment to The Standard.
- 4 Follow the instructions outlined in your Waiver of Premium claim approval letter for any adjustment of premium due to you. Make this adjustment on your next Premium Remittance Statement under the Retro Adjustments section by line of coverage if applicable.

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Questions? Call 1-800-522-0406

Paying Premiums for Disability Insurance During Disability

Follow these steps when an insured Participant is away from work because of disability and a Disability claim is pending.

- 1 Continue paying premiums until you receive notification that the Disability claim is approved and benefits are payable and due, as long as the Participant remains eligible for coverage.
- 2 After you receive notice of claim approval, report the changes for premiums following the steps under Participant Adjustments in this section of the guide.

Paying Premiums When Evidence Of Insurability Is Pending

When Evidence Of Insurability is required, the portion of coverage subject to medical underwriting is not in force until an application is approved in writing by The Standard.

- 1 Pay premiums for only the amount of coverage (if any) for which the Participant is eligible without submitting evidence.
- 2 Then adjust your premiums to add or increase coverage (if applicable) after you receive formal notification from The Standard of approval and of the approved amount, assuming the Active Work Requirement has been met. See your Certificate and the section titled “About Evidence Of Insurability” in this guide.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Common Questions About Billing Administration

About Premium Billings and Participant Changes

When are premiums due?

Premiums are due on the first calendar day of the period for which they are billed. For example, premiums due for the month of March are due on or before March 1.

When will my billing statement be mailed?

Typically, statements are mailed 11 days before each due date. AdminEASE subscribers can view a current summary of lives, volume, and premium, which is available online monthly after statements have been printed at The Standard.

How does The Standard calculate volume?

Insurance volume is generally calculated as follows for each individual insured under your Certificate:

- Term Life and AD&D: The insured Participant's volume equals the benefit amount.
- Disability: Volume equals the insured Participant's Regular Monthly Contract Salary. To determine premium, find the band in which the insured Participant's Regular Monthly Contract Salary falls to find the premium.

See your Certificate for maximum amounts and rate tables.

Should I pay as billed or make my own adjustments?

Make all current changes to the bill and submit premium accordingly. Calculate and pay premiums according to the instructions in the section titled "Paying Premiums" in this guide.

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Questions? Call 1-800-522-0406

Why weren't my Participant changes reflected on my current census?

Either The Standard did not receive the changes before preparing your billing statement, or we did not receive all of the information needed to process the change. If you have any questions about employee changes, call the Standard at 1-800-522-0406.

Can I make my Participant changes over the phone?

No. To assure accuracy, The Standard requires that all changes be requested in writing. If you are concerned that changes you have submitted are not reflected on your statement, call The Standard at 1-800-522-0406.

About Forms

Where do I get forms?

You can print forms from www.standard.com/cta. You may also order forms by calling 1-800-522-0406.

My district uses its own forms. Can I continue to use our forms?

Use The Standard's forms to avoid delays and confusion. However, if your school district has a form approved by The Standard for continued use, you may use it.

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Questions? Call 1-800-522-0406

Administration of Group Life and AD&D Benefits

Summary of Responsibilities

- Make required claim forms available to your insured Participants.
- Complete employer portions of benefit claim forms and provide required attachments.

Submitting a Claim for Group Life Insurance and Accidental Death

These instructions apply to Life, Accidental Death, Dependents Life, and Supplemental Life. To assist an applicant in filing one of these claims, use a Life Claim Packet, obtainable at www.standard.com/cta.

- 1 Complete the Proof of Death Claim form.
- 2 Send the Proof of Death Claim form to The Standard at the address listed on the form, including the following attachments:
 - All of the Participant's enrollment forms, change forms, and Beneficiary Designation forms (including any forms from previous carriers)
 - A certified copy of the decedent's death certificate
 - Any other documents that provide additional information for the claim, such as an accident report for Accidental Death claims
- 3 Instruct the beneficiary to complete the Life Insurance Benefits Beneficiary Statement and send it to The Standard.

Questions? Call 1-800-522-0406

Submitting a Claim for Accidental Dismemberment

Typically, Participants notify The Standard by phone of an Accidental Dismemberment claim, so you need only complete the Employer Statement. However, if a Participant requests your assistance, follow these steps to help a Participant submit an Accidental Dismemberment Claim Packet.

Note: If your Participants pay all or a part of their premiums, The Standard retains enrollment forms. However, if your District retains enrollment forms, include photocopies of these with the submitted claim.

- 1 Complete the Employer Statement.
- 2 Give the Participant the Accidental Dismemberment Claim Packet, which contains the following:
 - Instructions for the forms
 - Your completed Employer Statement
 - Employee Statement
 - Claim Form Fraud Notices
 - Authorization to Obtain Information
 - Authorization Disclosure
 - Attending Physician's Statement
- 3 If needed, give the Participant a photocopy of the Participant's enrollment form.
- 4 Instruct the Participant to do the following:
 - Sign and date the Authorization, complete the Employee Statement and send these, including the Employer Statement, directly to The Standard.
 - Complete the top portion of the Attending Physician's Statement and provide the form and a Fraud Notice to the physician, requesting that the physician complete the remainder of the form and send it to The Standard.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Submitting a Claim for Waiver Of Premium When Participants Don't Have Disability Coverage

When the Participant does not have Disability coverage, use a Waiver Of Premium Claim Packet to submit a claim.

- 1 You complete the Employer Statement and send the form to The Standard. Include the following:

- Job description
- Employment application or resume

Note: Make copies of the forms for your records and send all originals to The Standard.

- 2 Instruct the insured Participant to submit a claim via telephone to our claim intake team.

If the Participant prefers to complete a paper form, advise the Participant to use a Waiver Of Premium Claim Packet (which can be printed from www.standard.com/cta) and do the following:

- Complete, sign and date the Employee Statement, sign and date the Authorizations and send these forms directly to The Standard.
- Complete Part A of the Attending Physician's Statement, give the form and an envelope to the physician for completion of Part B and direct the physician to send the form to The Standard.

- 3 If insurance has not ended, pay premiums until you are notified that the Waiver claim is approved.
- 4 Advise the Participant that The Standard may directly request additional proof of disability.
- 5 Notify The Standard if the Participant recovers, returns to work, or dies.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Submitting a Claim for Waiver Of Premium When Participants Have The Standard's Disability Coverage

Separate Waiver Of Premium claim forms are not required if you have already completed Disability claim forms.

- 1 Notify the Participant that The Standard will work directly with the Participant to determine eligibility for Waiver Of Premium.
- 2 If insurance has not ended, pay premiums until you are notified that the claim is approved.
- 3 Notify The Standard if the Participant recovers, returns to work or dies.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Common Questions About Group Life Insurance Benefits

Where can I obtain claim forms?

You can print forms from www.standard.com/cta.

Whom does The Standard pay if no Beneficiary is named?

The Group Policy includes a provision that applies if no Beneficiary is named. Payment is generally made to the first of the following classes in which an individual has survived the insured Participant: Spouse/ Domestic Partner, Children, Parents, Siblings, and Estate.

Does The Standard pay minors if they are listed as Beneficiaries?

Life Insurance proceeds that are due and owing to a minor beneficiary will be paid in accordance with applicable state law. It may be necessary to have a conservator appointed for the estate of the minor in order to make payment.

Can a person who has Power of Attorney for the insured Participant change a Beneficiary designation?

Whether a Power of Attorney permits an attorney-in-fact to make or change a beneficiary designation on behalf of a Participant depends on applicable law. The Participant or attorney-in-fact should consult a legal advisor with questions.

Why does The Standard need the beneficiary's Social Security number?

The Standard is required to file a 1099 Interest Income form when interest is paid on the proceeds of the Life Insurance policy. The Social Security number is required to complete the form.

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Questions? Call 1-800-522-0406

What are the options for Beneficiaries to receive policy proceeds?

Typically, beneficiaries are paid by check. However, when the proceeds exceed \$25,000 for your Group Policy, they are deposited in an interest-bearing account, Standard Secure Access. The Beneficiary then receives a draft book instead of a check, funds begin earning interest the day the claim is paid, and the beneficiary may make withdrawals at any time in amounts of \$250 or more.

What is Waiver Of Premium?

Waiver Of Premium is a provision of a Group Life Insurance policy that allows an eligible insured Participant to have Life and Dependents Life Insurance continued without paying premiums for a specified period of time. The Participant must meet Group Policy requirements, including the definition for Total Disability.

When is an insured Participant eligible for Waiver Of Premium?

A Participant is eligible for Waiver Of Premium when the Participant is Totally Disabled as defined by the Group Policy, and meets the age requirement.

What happens if a Participant who has been on Waiver Of Premium recovers?

A Waiver claim is closed if recovery occurs after a claim is approved.

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Questions? Call 1-800-522-0406

When is the appropriate time to provide a Participant with Waiver Of Premium claim forms instead of a Conversion card?

Provide Waiver Of Premium claim forms when an insured Participant stops working because of Sickness or Injury, as defined in your Group Policy. Conversion cards are appropriate for Participants whose insurance terminates for non-medical reasons or are otherwise not entitled to Waiver Of Premium.

No additional claim forms beyond the Disability claim forms are required if your school district has Disability Insurance through California Teachers Association or if the Participant has Voluntary coverage through California Teachers Association.

Questions? Call 1-800-522-0406

Administration of Group Disability Benefits

Summary of Responsibilities

- Make required claim forms available to your insured Participants
- Complete employer portions of benefit claim forms and provide required attachments.

Submitting a Claim for Disability Benefits

Follow these steps when assisting a Participant.

- 1 Provide the Participant with the Instructions, a Employee Statement, Authorizations to Obtain Information and Attending Physician's Statement. Instruct that the Participant do the following:
 - Complete, sign and date the Employee Statement, sign and date the Authorizations to Obtain Information, and then send these forms to The Standard.
 - Complete Part A of the Attending Physician's Statement, give the form, envelope and fraud notice to the physician and instruct physician to complete Part B and send the form to The Standard.
- 2 Complete the Employer Statement and send it to The Standard with the following:
 - Job description and/or completed Job Analysis form
 - Employment application or resume
 - All enrollment and change forms **if** the Participant has Life Insurance with The Standard
 - Documentation of any Deductible Income as defined by the Group Policy
 - Documentation of any Extra Duty Pay contract the Participant may have for a future Extra Duty Pay assignment.

Questions? Call 1-800-522-0406

Common Questions About Group Disability Benefits

At what point should I encourage a disabled Participant to file a claim for Disability benefits?

Typically, The Standard advises that a Disability claim be filed no later than half way through the employee's Benefit Waiting Period, as defined in your Certificate.

Where can I obtain claim forms?

You can print forms from www.standard.com/cta.

How frequently are Disability benefits paid after a claim has been approved?

Disability benefits are paid on a monthly basis at the end of the calendar month. For example, if the disability date is March 5 and the Benefit Waiting Period is 7 Regular Days of Required Attendance, the Benefit Waiting Period might end on March 14. Benefits would become payable on March 15, the first benefit check would be paid by April 1, and subsequent benefit checks would be paid to the Participant by the first of each month.

What options do Participants have for receiving their Disability benefits?

The Standard offers three Disability benefit payment options:

- Regular check: The Standard will mail a check to the Participant's address, allowing sufficient time to reach the Participant by the date the benefits are due.
- Electronic Funds Transfer (EFT): If the Participant elects EFT, The Standard will wire transfer Disability benefits to the Participant's designated bank account by the date that the benefits are due.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

- The Standard SecureCardSM: When the Participant selects The Standard SecureCardSM, which is similar to an ATM or debit card, The Standard will wire transfer Disability benefits to the Participant's account by the date that benefits are due. The Participant then has the option of transferring money from the card to other personal banking accounts or using the card at ATMs or for point-of-sale purchases.

What should I do when a Participant with a pending or active Disability claim returns to work or dies?

If a Participant who has a current Disability claim with The Standard returns to work in any capacity or dies, immediately notify the assigned Benefits Analyst. The Benefits Analyst will request additional information as needed to determine whether further benefits may be payable under the terms of the Group Policy.

How may I obtain information regarding claims submitted for my organization?

The Standard offers the reports and services to keep you informed about the status and payment of Disability benefits under your Group Policy.

- Monthly Group Benefits Activity Report: Automatically sent to you at the end of each month, this provides a summary of benefit payments and/or activity during the month.
- Reports OnlineSM Claims Management Information: Available at no additional cost, this provides daily updates regarding claim status and payment activity, as well as quarterly case management reports for use in identifying claim trends. A signed service agreement is required to set up the Reports OnlineSM service.

The Standard's toll-free customer service line is available 24 hours per day, seven days per week. Our system provides basic claims information that corresponds with the Participant's Social Security number and birth date.

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Questions? Call 1-800-522-0406

Are Disability benefits subject to taxes?

Our records indicate you pay 100 percent of the premium for your Participants' Disability coverage. Thus, 100 percent of the Disability benefits are taxable. The Standard will submit W-2s at year-end showing the taxable amount according to IRS regulations. Advise insured Participants to consult their tax advisors for more specific information.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Appendix A: Forms

Form Name	Form Number	
Accidental Dismemberment Claim Packet	SI-2720	CTA
Beneficiary Designation & Change (School District)	SI-11210	CTAdp
Billing Change Form	SI-7270	CTAdp
Continued Life Insurance During Total Disability Claim Packet	SI-13391	CTA
Disability Claim, Employer Statement (District Paid)	SI-13388	CTAdp
Disability Claim Packet	SI-3379	CTA
Enrollment for School District Group Disability Insurance	SI-7533	CTAdp
Enrollment for School District Group Disability & Life Insurance	SI-7533	CTAdp1
Enrollment for School District Group Life Insurance	SI-7533	CTAdp2
Long Term Disability Conversion Application	SI-8826	CTA
Group Conversion Packet	SI-9563	CTA
Life Claim Packet	SI-1794	CTA
Life Portability Application (District Paid)	SI-9178	CTAdp
Medical History Statement	SI-8738	WCTAdp
Request for Group Life Conversion	SI-1598	A-CTA
Request for Long Term Disability Conversion	SI-4781	CTA
Waiver of Premium Claim Packet	SI-1284	CTA

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Appendix B: Guidelines for Self-Administered Plans

This supplement to the Group Insurance Administration guide for District Paid Plans provides guidelines for managing the Self Administered District Paid plans with The Standard. This information does not amend, alter or waive any provision in The Standard's Self Administered District Paid insurance plans.

Billing Administration

The Standard is pleased to assist you in your role as administrator. If you have any questions that are not answered by this guide, contact the Standard's CTA Call Center at 1-800-522-0406. As administrator, your responsibilities are these:

- maintaining a list of Insured Participants for premium billing
- preparing premium statements according to the number of Participants insured in your district
- determining the volume and the premium due, based on the number of Participants on your list

About Billing Adjustments: Billing adjustments are required to reflect 1) employee additions and terminations and (2) volume increases and decreases. These may result from changes in age, classification, salary, or other reasons as defined in your Certificate.

About Volume: Volume is the amount of coverage each insured Participant has according to the Certificate. Premiums for Life, AD&D, Dependents' Life and Disability are based on amounts stated in the Schedule of Insurance provisions of the Certificate.

This describes certain provisions of the Group Insurance Policy, but does not contain all terms and conditions. Please see your Certificate for full details.

Questions? Call 1-800-522-0406

Paying Premiums

To report insured Participants and premium due, use your [Premium Remittance Statement](#), which accompanies your bill.

- 1 Determine the number of insured Participants and the volume by line of coverage. (That is, determine who is being added or terminated or who has experienced some other premium-related change. Use the rate tables to determine premium.)
- 2 Complete the statement by coverage type:
 - Summarize your Participants.
 - Summarize volume.
 - Summarize premium adjustments.
 - Calculate total premium due.
- 3 Attach supporting documentation.
- 4 Prepare your check for the amount due as described in the Administration Guide for District Paid Group Insurance Plans.
- 5 Return the Statement of Premium Due with your payment to The Standard as described in the Administration Guide for District Paid Group Insurance Plans.

Note: Do not pay premiums for coverage or amounts for which Evidence Of Insurability is pending (or for which Evidence Of Insurability is required but has not been submitted).

When You Have No Adjustments

If there have been no changes in your district that would affect the Participants covered by this Self Administered plan, simply complete the statement showing no adjustments and then pay the total premium due.