



The Standard®
Positively different.

Voluntary Life Insurance

FOR EMPLOYEES OF EMPLOYERS PARTICIPATING IN THE
WASHINGTON COUNTIES INSURANCE FUND

Answers to your questions about coverage from Standard Insurance Company



About This Booklet

This booklet is designed to answer some common questions about the group Voluntary Life insurance coverage being offered by Washington Counties Insurance Fund for participating *employers* with eligible employees. It is not intended to provide a detailed description of the coverage.

If coverage becomes effective and you become insured, you will receive a web link to a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the *group policy* issued by Standard Insurance Company. Neither the certificate nor the information presented in this booklet modify the *group policy* or the insurance coverage in any way. If you have additional questions, please contact your human resources representative.

Please note that defined terms and provisions from the *group policy* are italicized in this booklet.



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Voluntary Life Insurance Features

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you suddenly died?

Would they have the funds to pay bills, your home mortgage, burial and funeral expenses? Would they be able to live on one income and maintain their current lifestyle? What about medical expenses associated with a terminal illness? Would your family be financially prepared? By sponsoring group Voluntary Life insurance from Standard Insurance Company, your *employer* offers you an excellent opportunity to help protect your loved ones.

The advantages to you and your family include:

- **Choice.** You decide how much coverage you need from the range of amounts available.
- **Flexibility.** If your needs change, you can request to change the amount of coverage.
- **Convenience.** With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments.
- **Peace of Mind.** You can take comfort and satisfaction in knowing that you have done something positive for your family's future.

Commonly Asked Questions

The following information provides details to give you a better understanding of group Voluntary Life insurance available from The Standard. Written in non-technical language, this is not intended as a complete description of the coverage.

Am I eligible for this coverage?

To be a *member* and eligible for the Voluntary Life coverage, you must be insured for Basic Life Insurance under Group Policy 645273-B and one of the following:

- An active employee of Whatcom County working at least 80 hours each month;
- An active employee of an *employer* participating in the Washington Counties Insurance Fund who is regularly working at least 20 hours each week; or
- An elected official of an *employer*

A *member* does not include temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors

For your *spouse* or *dependent* to be eligible for coverage, they must not be full-time members of the armed forces of any country.

When does my insurance go into effect?

The effective date of your coverage depends on when you become an eligible *member*, when you apply and whether you are required to provide *evidence of insurability*.

If you are **not** required to provide *evidence of insurability*, your Voluntary Life coverage becomes effective on:

- The date you become eligible if you apply on or before that date; or
- The date you apply if you apply within 31 days after you become eligible.

If you are required to provide *evidence of insurability*, your Voluntary Life coverage becomes effective on the date The Standard approves your *evidence of insurability*.

In every case, you must apply and agree to pay premiums and meet the *active work* requirement before your insurance becomes effective.

What is the active work requirement?

Active work means performing with reasonable continuity the material duties of your own occupation at your *employer's* usual place of business. You must be capable of *active work* on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are not *actively at work* on the day before the scheduled effective date of insurance including Dependents Life insurance, your insurance will not become effective until the day after you complete 1 full day of *active work* as an eligible employee.

How much coverage may I get for myself?

You may elect Voluntary Life coverage in units of \$10,000. The maximum amount when combined with any Basic Life Insurance for which you are insured under Group Policy 645273-B is the lesser of 6 times your *annual earnings* and \$500,000. If you want to become insured for an amount of Voluntary Life greater than the *guarantee issue amount* of \$50,000, you must provide satisfactory *evidence of insurability*. All late applications and requests for coverage increases also require satisfactory *evidence of insurability*.

May I get coverage for my spouse and children?

Dependents Life insurance for your *spouse* is available in units of \$10,000 to a maximum of \$250,000, but not to exceed 100 percent of your Voluntary Life coverage. If you elect an amount of Dependents Life coverage for your *spouse* greater than the *guarantee issue amount* of \$20,000, your *spouse* must provide satisfactory *evidence of insurability*. You may also elect Dependents Life insurance for your eligible *children* in units of \$2,000 to a maximum of \$10,000, but not to exceed 100 percent of your Voluntary Life coverage. Each of your *children* will be insured for the same amount.

All late applications for Dependents Life insurance and requests for coverage increases require satisfactory *evidence of insurability*.

Will I have to provide information regarding my medical history?

If you apply for Voluntary Life insurance within 31 days of becoming eligible to apply and meet the *active work* requirement, you will automatically qualify for up to a set amount of insurance coverage called the *guarantee issue amount*. This means that you will not have to answer medical questions to purchase coverage up to this amount.

If you apply more than 31 days after becoming eligible to apply or if you determine that you need more insurance than the *guarantee issue amount*, satisfactory *evidence of insurability* is required. You will need to complete and submit a Medical History Statement. In some cases, we may request additional medical information or a physical exam.

Evidence of insurability is also required for reinstatement of terminated coverage and for coverage increases.

How much coverage do I need?

Each family has its unique set of circumstances, combined with needs that may arise with the unexpected loss of life. Use the worksheet below in calculating the amount of life insurance coverage you may need. The total is the amount of Voluntary Life insurance you might want to consider applying for to meet your obligations. Once you determine how much coverage you need, complete the Enrollment Form within your enrollment packet, place it in a confidential envelope and submit it to your human resources department.

Immediate Needs	You	Your Spouse
Medical and hospital expenses	\$ _____	\$ _____
Funeral/Burial expenses	_____	_____
Loans/Debts requiring payment upon death	_____	_____
Taxes:		
Federal and state income taxes	_____	_____
Property taxes	_____	_____
Federal and state estate taxes	_____	_____
Long Term Needs		
Mortgage	\$ _____	\$ _____
Debts (credit cards, car and student loans, etc.)	_____	_____
Educational/Vocational fund	_____	_____
Childcare expenses	_____	_____
Emergency fund for unforeseen expenses	_____	_____
Income Replacement		
Consider the income needed to support your family and the number of years they may need that support.	\$ _____	\$ _____
Total Income Needs		
Add together all of the above.	\$ _____	\$ _____
Available Resources		
Existing life insurance coverage	\$ _____	\$ _____
Other assets such as 401(k), stocks, bonds, etc.	_____	_____
Total Available Resources		
Add together all of your available resources	\$ _____	\$ _____
Total Voluntary Life Insurance Needed		
Subtract the amount of your total available resources from your total income needs.	\$ _____	\$ _____

How are benefits paid?

Our goal is to make a determination on life insurance claims within six business days of receipt in our home office and, when appropriate, make a payment within one business day of our approval. Depending upon the approved claim amount, The Standard may either issue a check to your designated *beneficiary* as a lump-sum payment or deposit the funds into a Standard Secure Access account.

With Standard Secure Access—a convenient, no fee, interest-bearing draft account—each *beneficiary* receives a personalized checkbook and has complete control of the account. *Beneficiaries* can write checks as needed or for the full amount. This arrangement allows *beneficiaries* to earn competitive interest rates on their benefits while they take the necessary time to consider financial decisions and evaluate their choices.

Will insurance benefits be reduced as I grow older?

Under this plan, your Voluntary Life coverage reduces to 65 percent at age 70, 45 percent at age 75, and 30 percent at age 80. If you are age 70 or over, ask your human resources representative for the amount of coverage available. Dependent Life Insurance for your *spouse* terminates on the date your *spouse* becomes 70 years of age.

What happens if I become totally disabled and can't work?

The Standard may continue your Voluntary Life and any Dependents Life insurance without payment of premium if you are insured under the *group policy* and:

- Are under the age of 60
- Become *totally disabled*
- Complete the *waiting period* of 180 days
- Provide The Standard with satisfactory *proof of loss*

The amount of insurance continued under the *Waiver of Premium* provision will be reduced or terminated according to the *group policy*.

What happens if I become terminally ill?

Under the *Accelerated Benefit* provision, you may be eligible to receive up to 75 percent, or a maximum of \$500,000, of your Voluntary Life insurance coverage if you become terminally ill, have a life expectancy of less than 24 months and meet other eligibility requirements.

This benefit allows you to use the proceeds as you desire — whether to cover medical expenses or to maintain your quality of life. The amount of Voluntary Life insurance payable upon your death is reduced by the *Accelerated Benefit* paid and an interest charge. However, to help protect your *beneficiaries*, The Standard will pay at least 10 percent of the original Voluntary Life coverage amount even if interest charges on the accelerated amount would have exhausted the remaining benefits over time.

Are there any other benefits with the Voluntary Life insurance coverage from The Standard?

The Standard pays an additional benefit, the *Repatriation Benefit*, if you die more than 200 miles from your primary place of residence. The Standard will pay for expenses, up to a benefit maximum, incurred to transport your body to a mortuary near your primary place of residence.

The Standard includes a travel assistance program that provides a full range of 24-hour medical, legal and travel assistance services to you and your dependents when you travel more than 100 miles from home or in a foreign country.¹

When does coverage end?

Voluntary Life coverage ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid for your Voluntary Life insurance (except if premiums are waived while *totally disabled*, if applicable)
- The date your employment terminates, or 31 days after your employment terminates, if you are an employee of Whatcom County.
- The date the *group policy* terminates
- The date you cease to be a *member*; however, insurance may continue for limited periods under certain circumstances described in the *group policy*
- The date your *employer* ceases to participate under the *group policy*

Dependents Life coverage for your *spouse* and *children* ends automatically on the earliest of the following:

- Five months after the date you die (no premiums will be charged for your Dependents Life insurance during this time)
- The date your Voluntary Life insurance ends
- The date Dependents Life insurance terminates under the *group policy*
- The date the last period ends for which a premium was paid for your Dependents Life insurance
- When the *dependent* ceases to be an eligible *dependent*
- For your *spouse*, the date of your divorce or termination of your *domestic partner* relationship
- For your *spouse*, the date they reach age 70
- For a *child* who is *disabled*, 90 days after we mail you a request for proof of *disability*, if proof is not given

If my Voluntary Life or Dependents Life insurance ends or reduces, may I convert it to an individual policy?

If your Voluntary Life or Dependents Life insurance from The Standard ends or reduces for any reason other than failure to pay premiums, the *Right to Convert* provision allows you to convert your Voluntary Life or Dependents Life coverage to certain types of individual life insurance policies without having to provide *evidence of insurability*. You must apply for conversion and pay the required premium within 31 days after group coverage ends or reduces.

¹ Provided through an agreement with MEDEX® Assistance Corporation.

May I buy group life coverage after I leave my employer?

If your insurance ends because your employment terminates, you may be eligible to buy group life insurance from The Standard through the Portability of Insurance provision, assuming you meet the eligibility requirements. Please see your human resources representative for additional information.

How much will the Voluntary Life coverage cost?

The monthly premium rates for the group Voluntary Life coverage are shown below.

Age of Employee on last December 31	Monthly premium rate per \$10,000 of Voluntary Life coverage
Age 19 and under	\$0.56
Age 20 through 24	\$0.66
Age 25 through 29	\$0.71
Age 30 through 34	\$0.82
Age 35 through 39	\$0.98
Age 40 through 44	\$1.45
Age 45 through 49	\$2.35
Age 50 through 54	\$3.91
Age 55 through 59	\$5.81
Age 60 through 64	\$8.74
Age 65 and above	\$12.53

To calculate the monthly payroll deduction for your Voluntary Life coverage, use the rates above and the formula below:

1. Enter amount of Voluntary Life coverage elected on Line 1 Line 1: \$	_____
	÷ 10,000
2. Divide the amount on Line 1 by 10,000 and enter on Line 2 Line 2: \$	_____
3. Find your rate in the rate table and enter on Line 3 Line 3: \$	_____
4. Multiply Line 2 by the amount shown on Line 3 Line 4: \$	_____

The amount shown on Line 4 is your estimated monthly payroll deduction. Premiums for the Voluntary Life coverage will be deducted directly from your paycheck.

How much will the Dependents Life coverage cost for my spouse and children?

The monthly premium rates for *spouse* coverage are shown below.

Age of Spouse on last December 31	Monthly premium rate per \$10,000 of Dependents Life coverage
Age 19 and under	\$0.60
Age 20 through 24	\$0.70
Age 25 through 29	\$0.75
Age 30 through 34	\$0.90
Age 35 through 39	\$1.05
Age 40 through 44	\$1.55
Age 45 through 49	\$2.45
Age 50 through 54	\$4.09
Age 55 through 59	\$5.87
Age 60 through 64	\$9.57
Age 65 and above	\$13.53

To calculate the monthly payroll deduction for your *spouse's* Dependents Life coverage, use the rates above and the formula below:

1. Enter amount of Spouse coverage elected on Line 1	Line 1: \$ _____
	_____ ÷ 10,000
2. Divide the amount on Line 1 by 10,000	Line 2: \$ _____
3. Find your <i>spouse's</i> rate in the rate table and enter on Line 3	Line 3: \$ _____
4. Multiply Line 2 by the amount shown on Line 3	Line 4: \$ _____

The amount shown on Line 4 is the estimated monthly payroll deduction for Dependents Life coverage for your *spouse*.

The premium for Dependents Life coverage for eligible children is \$.44 a month per \$2,000 of Dependents Life coverage regardless of the number of children covered. Premiums for any Dependents Life coverage will be deducted directly from your paycheck.

How do I apply for Voluntary Life insurance coverage?

To apply for Voluntary Life insurance, complete the Enrollment Form in your enrollment packet, place it in a confidential envelope and submit it to your human resources department. You can apply at any time, but remember if you apply more than 31 days after becoming eligible, satisfactory *evidence of insurability* is required. Coverage subject to *evidence of insurability* is not effective until approved by The Standard.

What if I have additional questions?

If you have any additional questions, please contact your human resources representative.

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. Complete all items, date and sign in the space at the bottom of page 2. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Please keep a copy for your records.

MEMBER/EMPLOYEE INFORMATION

Name of Group and Group Number Washington Counties Insurance Fund/Pool – 645273		Employer Name and Location		Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name			Birthdate (Mo/Day/Year)		Date Hired (Mo/Day/Year)
Occupation		Salary	Social Security Number		Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)					
Street Address			City		State Zip
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (Mo/Day/Year)	Birthplace		Social Security Number	Work Phone () Home Phone ()

APPLICATION INFORMATION

Type of Application (<i>check one</i>) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Late Application					
Check the type and provide details on the amount of coverage you are requesting.					
<input type="checkbox"/> Short Term Disability					
<input type="checkbox"/> Long Term Disability	_____	+	_____	=	_____
	Current Amount In Force, if any		Additional Amount Requested		Total Amount Requested
<input type="checkbox"/> Life					
	_____	+	_____	=	_____
	Current Amount In Force, if any		Additional Amount Requested		Total Amount Requested
<input type="checkbox"/> Dependents Life					
	_____	+	_____	=	_____
	Current Amount In Force, if any		Additional Amount Requested		Total Amount Requested

MEDICAL HISTORY STATEMENT QUESTIONS

- Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.**
- Are you now unable to work full-time because of any physical or mental condition, or injury? Yes No
 - Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
 - Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? Yes No
 - Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? Yes No
 - Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? Yes No
 - Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders? Yes No
 - Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? Yes No
 - Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)? Yes No
 - Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? Yes No
 - Diabetes, thyroid, gland, spleen, or nephritis? Yes No
 - Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? Yes No
 - Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder? Yes No
 - In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits? Yes No
 - Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
 - Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, or injury? Yes No
 - Are you currently pregnant? Yes No

Height	Weight	Physician Name or Medical Facility with Applicant's Complete Medical Records (provide name and full mailing address)			

Applicant Name	Social Security Number
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Describe any "yes" answers below. (Please provide the entire question number.)

Question Number	Description of Injuries, Disorders and Operations	Month/Year	Duration	Final Result	Physicians Consulted, City & State

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION (Please read carefully.)

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.

Signature of Applicant (or Member/Employee for Dependent Child)	Date
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Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

Applicant Name	Social Security Number
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INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.
 Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.
 Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

FRAUD NOTICE

- FOR RESIDENTS OF ARKANSAS, LOUISIANA, OHIO, WASHINGTON: 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 DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- 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.

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name Washington Counties Insurance Fund (WCIF)		Group Number(s) 645273	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		
	Employer			Job Title/Occupation		
LIFE	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> Voluntary Life <input type="checkbox"/> Employee Voluntary Life Your requested amount \$ _____					
	Dependents Life <input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Spouse Date of Birth _____ <input type="checkbox"/> Child requested amount \$ _____					
	<i>This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i>					
BENEFICIARY	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____					
	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
SIGNATURE	Member/Employee Signature Required				Date (Mo/Day/Yr)	
	Human Resources Department - Complete this section. Retain form for your records.					
Dvsn ID 01	Billing Cat. 0100	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 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 a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated _____.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.

About Standard Insurance Company

Your employer has chosen Standard Insurance Company to provide group Voluntary Life coverage to eligible employees. The Standard has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1906, The Standard has developed a national presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance.

Just as others count on you, you can count on The Standard for Voluntary Life insurance in a time of need. Talk with your employer's human resources representative for more information about group Voluntary Life insurance from The Standard.



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