Administration Guide for District-Paid Group Insurance Plans Endorsed by California Educators Insurance Plan (CEIP) for California Teachers Association (CTA)

Standard Insurance Company

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

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Using This Guide

This guide is designed to help you administer your District-Paid Group Insurance Plans provided by Standard Insurance Company (The Standard) and endorsed by California Educators Insurance Plans (CEIP) for 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. (That is, the first letter of the word is capitalized; however, some non-policy terms also have an initial cap.) Refer to your Certificate of Insurance, Index of Defined Terms or the table of contents to find these terms.

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.

Note: Some of the information in this guide may not be applicable to your district if you have a custom Group Policy.

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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 provide bills and 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.

Most importantly, our dedicated staff is here to help you. We have a team dedicated to your needs as the Administrator. Please contact us when that first question arises.

About the Various Plans

Some school districts provide District-Paid Disability Insurance, some provide District-Paid Life Insurance, and some provide both. Although this guide is for both plans, refer to your Certificate of Insurance for the details of your plans, and disregard any information that does not apply to your district.

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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Contacting The Standard

There are multiple ways to contact The Standard.

By Phone

Dialing 800.522.0406 toll-free will connect you to The Standard's dedicated Customer Service Department. Representatives can answer your calls from 7 a.m. to 6 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.

By Email

You may contact The Standard via email at ctaadmin@standard.com. The Standard's dedicated Customer Service Department will respond to your email by the next business day.

By Mail or Fax

Use the mailing addresses and fax numbers below to expedite processing forms and information.

Payments, Remittance Statements, Vendor Deduction Rosters
Standard Insurance Company
PO Box 4664
Portland, OR 97208-4664

Enrollment/Billing Forms, Documents, and Issues
Standard Insurance Company
PO Box 4744
Portland, OR 97208
Fax: 888-414-0393

Claims Forms, Documents, and Issues
Standard Insurance Company
PO Box 2773
Portland, OR 97208
Fax: 888-414-0390

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About The Standard's Forms

The Standard's forms are available for Administrators on our District Microsite at www.standard.com/cta. If you are unable to access the forms, please contact The Standard.

Use The Standard's forms to avoid delays and confusion.

AdminEASE: An Online Tool for Your Convenience

Access The Standard's online tool, AdminEASE, to do the following:

- view a summary of your bill
- view and download a list of insured Participants
- view medical evidence reports
- view claim reports

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.

Original forms should be submitted to The Standard; however, school districts typically retain copies of the enrollment, Beneficiary Designation, and change forms.

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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 of Insurance to determine any applicable eligibility and effective date requirements for a Participant,

- make sure the employee satisfies the Definition of Participant, including working at least the stated number of hours per week, and
- determine the effective date of coverage.

The Certificate of Insurance describes when Evidence Of Insurability (EOI) is required and when it is waived. If EOI is required, refer to the "About Evidence of Insurability" section in this guide.

Verifying Active Work

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

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When Insurance is Effective

Employer-Paid Coverage

New Participants who satisfy the Active Work Requirement have their coverage become effective on the date they become eligible (usually the first day actively worked).

Supplemental Life Insurance, Supplemental Plus Life Insurance, and Dependents Life Insurance

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
- If coverage is subject to Evidence of Insurability, premiums should not be deducted until coverage is approved by Medical Underwriting

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

- The date the Participant is eligible (usually the first day actively worked). ***OR***
- The first day of the calendar month following the date they apply, if their insurance is not subject to Evidence Of Insurance. ***OR***
- The first day 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.

Note: Insured Participants are subject to the Active Work Provisions in the Certificate of Insurance.

About Payroll Deductions for Participant Coverage

Start payroll deductions for Participant coverage when coverage becomes effective. (Refer to your Certificate of Insurance to determine the effective date of coverage.)

Enrolling Participants

The Standard's enrollment forms have 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 appropriate enrollment form, including the Beneficiary designation section.

Note: Beneficiary designations are also used for Disability Insurance (the Survivors Benefit and Accidental Death and Dismemberment). This section is optional.

- They must select any coverage desired in the Employee-Paid (contributory) section of the form, indicating any optional plans, if applicable.
- Enrollment in the plan may be contingent upon approval of Evidence Of Insurability by The Standard.

3 Review each form to be sure it is fully completed, including signature and date.

4 Provide each insured Participant a Certificate of Insurance as instructed in the section titled "Certificates and Notices" in this guide.

5 Original forms should be submitted to The Standard; however, school districts typically retain copies of the enrollment, Beneficiary Designation, and change forms.

6 Report changes and update billing, as instructed in the "Billing Administration" section in this guide.

Providing Coverage for the Dependents of Participants

Non-contributory Dependents Life Insurance is effective on the date the Participant becomes eligible, subject to the Active Work provision in the Certificate of Insurance.

Participants may have Dependents who are eligible for contributory coverage.

Contributory Coverage

To apply for contributory Dependents Life Insurance, Participants must

- submit an application for Dependents Life Insurance (on the applicable enrollment form)
- pay required premium
- satisfy Evidence Of Insurability (EOI) requirements, if applicable

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/coinciding with 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 Contributory Dependents Life

Start payroll deductions for contributory Dependents Life Insurance when coverage becomes effective (refer to your Certificate of Insurance for detailed information).

Designating a Beneficiary

About Beneficiary Designations

Insured Participants may designate one or multiple 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 of Insurance determine who will be entitled to the proceeds.

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 allow the Participant to attempt to make a change by altering an existing designation. Instead, ask the Participant to complete a new Beneficiary Designation / Change form.

1 Have the Participant complete, sign and date the form.

2 Advise the Participant to review the Beneficiary Information section of the form (this is usually on the second page).

3 Original forms should be submitted to The Standard; however, school districts typically retain copies of the enrollment, Beneficiary Designation, and change forms.

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About Evidence Of Insurability

Your Certificate of Insurance 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 requests 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.

All insurance subject to Evidence Of Insurability is also subject to your Certificate of Insurance's Active Work provision before the coverage becomes effective.

When Evidence of Insurability Is Required

Evidence Of Insurability may be required for the following coverages:

- Supplemental Life Insurance
- Supplemental Plus Life Insurance

Evidence Of Insurability is also required under the following circumstances:

- for reinstatement, if indicated by the Certificate of Insurance
- for contributory Dependents Life Insurance if written application is not made within 120 days of becoming eligible for dependents coverage
- for contributory Dependents Life Insurance if the 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
- for any increase in Supplemental Life Insurance, Supplemental Plus Life Insurance, or Dependents Life Insurance

Read your Certificate of Insurance to verify when Evidence Of Insurability is required. Refer also to the "Submitting for Evidence Approval" and "Notice of Approval or Declination" sections in this guide.

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

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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, contact The Standard for the appropriate form.

1 Provide the applicant a Medical History Statement.

2 Explain to the Participant that the form must be completed in its entirety, signed, and dated to avoid processing delays.

3 Mail or fax the completed form to The Standard.

Effective Date of Coverage Subject to Evidence of Insurability

Subject to Active Work Requirements, any amounts of coverage subject to Evidence Of Insurability are not effective until the first of the month following/coinciding with approval by The Standard.

Until you receive formal notification of approval and the Active Work Requirement has been met, do not deduct or submit premiums for the amount of 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 deducting and 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.

Changes, Terminations and Reinstatements

Summary of Responsibilities

Notify The Standard of Participant changes that affect billing using the appropriate form:

- Billing Change Form for salary changes and terminations
- Disability, Life, or Disability and Life Enrollment Form for coverage additions or increases
- Participant Change Form for other changes (this form should be completed, signed, and dated by the Participant)
- Beneficiary Designation Form for designations

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 of Insurance 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 of Insurance, adjust the coverage and your premiums, as appropriate, on the Premium Remittance Statement.

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 to be provided with a *Retiree Packet*. At that time, we will mail the Participant a retiree packet. Retirees must

- apply within 120 days of retirement by returning the appropriate forms provided in the Retiree Packet,
- authorize premium deduction from STRS/PERS, and
- pay the first month's premium payment beginning no later than the third month following application.

Important: If a retiree's 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 to

- complete and submit a Billing Change form to The Standard, and
- advise the retiring Participant about possible continuation of coverage.

Options When Insurance Reduces or Terminates

Your Certificate of Insurance 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 the Portability Of Insurance provision.

- **Disability Insurance:** When Disability coverage ends under the Certificate of Insurance, the insured Participant may be able to convert to an individual disability insurance policy.

See your Certificate of Insurance for specific information about the requirements Participants must meet to exercise these options when insurance terminates or reduces. Refer also to the "Administering Terminations and Reductions" section 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. Refer to the following sections in this guide and contact The Standard if you have questions.

- Refer to the "Waiver Of Life Insurance Premium" section under the "Benefits Administration for Group Life Insurance Benefits section.
- Refer to the "Premiums During Disability" section under the "Billing Administration," section.

Administering Terminations and Reductions

When insurance terminates or reduces, follow these steps.

1 Inform the insured Participant that coverage under the Certificate of Insurance is being reduced or terminated and specify the date this change becomes effective.

2 Determine the type of insurance coverage that is changing:

- For Disability Insurance conversion, refer to the "Applying for Disability Conversion" section in this guide.
- For Life Insurance conversion, refer to the "Applying for Life Conversion" section in this guide.
- For Life Insurance portability, refer to the "Applying for Life Portability" section in this guide.

3 Stop or adjust payroll deductions if the Participant was contributing toward the cost of insurance.

4 Report changes to The Standard on a Billing Change Form and update your billing according to the instructions in the "Administering Billing" section in this guide.

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Applying for Disability Conversion

Your Group Disability Policy includes a Conversion Of Insurance provision. This feature is available only to Class 2 Participants (those who participate in, but have fewer than five years of STRS/PERS credited service) whose insurance is not ending due to retirement or Disability. Refer to your Certificate of Insurance for details.

Steps for Applying to Convert Disability Coverage

1. Give Participants the *Request for Group Conversion Materials 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 within 31 days of the date the Participant's insurance ends.*

3. When the Participant returns the completed application to you, complete the Employer portion and sent the application to The Standard with premium payment. (Or instruct the Participant to do so, after the entire application is completed.)

Applying for Life Conversion

Your Group Life Policy includes a Conversion Of Insurance provision (refer to your Certificate of Insurance for eligibility details).

Steps for Applying to Convert Life Coverage

1. Give Participants the *Request for Group Conversion Materials 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 Life Conversion Insurance* to be completed by you and the Participant.

   Note: *This application and premium payment must be submitted within 31 days of the date of termination or reduction of the Participant's insurance.*

3. When the Participant returns the completed application to you, complete the Employer portion and sent the application to The Standard with premium payment. (Or instruct the Participant to do so, after the entire application is completed.)

Applying for Life Portability

Your Group Life Policy includes a Portability Of Insurance provision (refer to your Certificate of Insurance for details surrounding eligibility).

Steps for Applying to Buy Portable Life Insurance

1. Instruct Participants to contact The Standard.

2. Explain that The Standard will provide appropriate application materials and application instructions to the Participant

   Note: *This application and premium payment must be submitted within 31 days of the date the Participant's employment terminates or their occupation changes so that they are no longer eligible under the Group Policy.*

Reinstating Insurance Coverage

Reinstating insurance coverage may apply to Participants:

- who were formerly insured under the Certificate of Insurance and who return to work, or
- for whom insurance ended because of a withdrawal from the insurance coverage, reduction in work hours, or other reasons.

1 Refer to your Certificate of Insurance's Reinstatement Of Insurance provision to determine requirements.

2 If required, instruct the Participant to submit Evidence Of Insurability (refer to the "About Evidence Of Insurability" section of this guide).

3 Complete enrollment forms as instructed in the "Enrolling New Participants" section of this guide.

4 Report changes and adjust billing as appropriate (refer to the "Making Participant Adjustments" section of this guide).

Certificates and Notices

Summary of Responsibilities

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

Personalized Certificates for California

California law requires personalized certificates for group life, disability, and health insurance when insured employees pay all or part of the premiums. The certificates must contain either the name of the insured employee or otherwise identify each employee's individualized certificate. Please contact The Standard's dedicated Customer Service Department if you need assistance with compliance, including providing you with stickers for the certificates.

Distributing Information to Insured Participants

The Standard supplies you with Certificates of Insurance for insured Participants, which describe the coverage available under the Group Policy. If your 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 of Insurance when their insurance becomes effective. Distribute Certificates of Insurance to insured Participants 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.
- Contact The Standard if you need additional Certificates.

Billing Administration

Summary of Responsibilities

- Pay premiums when they are due.
- Include appropriate documentation along with your premium payment (based on your bill type).
- Notify The Standard of Participant changes using the appropriate form (refer to the "Eligibility and Enrollment" and "Changes, Terminations and Reinstatements" sections in this guide).
- Monitor benefit claims to assure proper coordination with premium deductions and payments to The Standard.

About The Standard's Bill Types

The three different bill types for CEIP endorsed plans are Census Bill, Self-Administered Bill, and List Bill. Typically, we mail billing statements 11 days before the premium due date.

About Premium Due Dates and Grace Periods

Premiums are due on the first calendar day of the period for which you are billed. Contact The Standard with questions regarding premium due dates for negotiated payment schedules.

Timely payment of premiums is required for Participants to remain insured. Your Grace Period is 60 days. If premiums are not paid within that grace period, Participant insurance coverage may end.

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General Information About Census Bills

You will receive one bill for each billing division. These bills consist of:

- The first pages are the census, which is a roster of all insured Participants and their individual premiums. The final page of the census shows subtotals of volume and premium by coverage (these are based on our current information, and may not be up to date).
- The last page, called a Premium Remittance Statement, is for your use in reporting the correct volume and premium to support your premium payment.

For more information, refer to Appendix A: Annotated Census Bill and Premium Remittance Statement.

Census Bill: Paying Premiums

1 Review the billing census against your records.

2 Report the total number of lives (insured Participants) on the Premium Remittance Statement.

3 Report the premium amounts due by coverage on your Premium Remittance Statement.

4 Make your check payable to Standard Insurance Company. Include your district's policy number and division number on the check.

5 Return the Premium Remittance Statement and your payment in the envelope provided. The Standard's premium PO Box is also listed in the "Contacting The Standard" section of this guide.

Census Bill: Making Participant Adjustments

You are responsible for reporting and making billing adjustments to reflect Participant additions, terminations, and volume increases and decreases.

To ensure your reported lives and premium match your records, forward original enrollment and change forms to The Standard upon receipt (refer to the "Eligibility and Enrollment" and "Changes, Terminations and Reinstatements" sections in this guide.

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General Information About Self-Administered Statements

You will receive one statement for each billing division. The Self-Administered statement contains areas to report lives (number of insured Participants), volume of coverage (total amount of each type of coverage), and the premium due for each type of coverage. A statement should be completed for each billing division.

For more information, refer to Appendix B: Annotated Self-Administered Statement.

Self-Administered Statement: Paying Premiums

1 Review your records to determine lives, volume, and premium by coverage type.

2 Report the total number of lives, volume, and premium by coverage type on the statement (keep a copy for your records).

3 Make your check payable to Standard Insurance Company. Include your district's policy number and division number on the check.

4 Return the Self-Administered Statement and your payment in the envelope provided. The Standard's premium PO Box is also listed in the "Contacting The Standard" section of this guide.

Self-Administered Statement: Making Participant Adjustments

You are responsible for reporting and making billing adjustments to reflect Participant additions, terminations, and volume increases and decreases.

You do not need to forward forms to The Standard for Self-Administered billing divisions. Instead, retain the forms for your records and use them to aid completing the statement each month.

When You Have No Adjustments

If there have been no Participant changes since your last statement, complete the statement reflecting the same lives, volume, and premium as the prior month.

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General Information About List Bills

You will receive one bill for each billing division. These bills consist of:

- The first pages are the census, which is a roster of all insured Participants and their individual premiums. The final page of the census shows totals of volume and premium by coverage, and any adjustments that have occurred since the last bill.
- The last page is a payment coupon to include with your premium payment.

List Bill: Paying Premiums

1 Report the amount of premium you are paying on the payment coupon.

2 Make your check payable to Standard Insurance Company. Include your district's policy number and division number on the check.

3 Return the Premium Remittance Statement and your payment in the envelope provided. The Standard's premium PO Box is also listed in the "Contacting The Standard" section of this guide.

List Bill: Making Participant Adjustments

To ensure your bill remains current, forward original enrollment and change forms to The Standard upon receipt (refer to the "Eligibility and Enrollment" and "Changes, Terminations and Reinstatements" sections in this guide.

Paying Premiums During Disability Benefits

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 Benefits

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 statement as applicable, based on your bill type.

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 in the applicable "Participant Adjustments" section of the guide, based on your bill type.

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 approval of Evidence Of Insurability.

2. 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 (refer to your Certificate of Insurance and the "About Evidence Of Insurability" section in this guide).

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 with Census or List Bills can view a current census list of lives, volume, and premium, which is available online monthly after statements have been printed at The Standard.

Why weren't a Participant's changes reflected on my current bill?

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. Contact The Standard if you have any questions about employee changes.

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, use the appropriate form to communicate those changes, or contact The Standard.

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Questions? Call 800.522.0406 or email ctaadmin@standard.com

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 on The Standard's District Microsite at www.standard.com/cta or by contacting The Standard.

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.

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

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.

Note: Participants also have the option of contacting The Standard to submit a claim over the phone.

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

Submitting a Claim for Waiver Of Premium When Participants Do Not 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 The Standard's District Microsite at 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.

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.

Common Questions About Group Life Insurance Benefits

Who does The Standard pay if no Beneficiary is named?

The Certificate of Insurance 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.

What are the options for Beneficiaries to receive policy proceeds?

Typically, beneficiaries are paid by check. However, when the proceeds exceed $25,000, 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 Certificate of Insurance 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 Certificate of Insurance, 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. You would then resume collecting premiums based on the Participant's coverage.

When is the appropriate time to provide a Participant with Waiver Of Premium claim forms instead of directing them to apply for Conversion?

Provide Waiver Of Premium claim forms when an insured Participant stops working because of Sickness or Injury, as defined by your Certificate of Insurance. Conversion may be appropriate for Participants whose insurance terminates or is reduced and who are not entitled to Waiver Of Premium (refer to the "Applying for Disability Conversion" and "Applying for Life Conversion" sections in this guide and your Certificate of Insurance).

Additional claim forms beyond the Disability claim forms are not required if your school district has Disability Insurance through CTA or if the Participant has Voluntary Disability coverage through CTA.

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, an 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 Certificate of Insurance
   - Documentation of any Extra Duty Pay contract the Participant may have for a future Extra Duty Pay assignment.

Note: *Participants also have the option of calling The Standard to submit a claim over the phone.*

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 by your Certificate of Insurance.

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.
- 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.

Common Questions About Group Disability Benefits (continued)

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 Certificate of Insurance.

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 Certificate of Insurance.

- 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 phone number is available 24 hours per day, seven days per week to provide automated basic claims information that corresponds with the Participant's Social Security number and birth date.

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. In addition, The Standard pays the employer's share of Social Security and Medicare taxes on your Participants' Disability benefits. Advise insured Participants to consult their tax advisors for more specific information.

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

Appendix A: Annotated Census Bill and Premium Remittance Statement

Billing Census

The Billing Census is a list of your Participants—and the coverages and costs for each—as of the print date of the census form. This is mailed to you approximately 11 days before the premium due date. **Only coverages appropriate to your school or organization will have volume, rate, and premium information.** Any other coverage categories can be ignored.

Start here when you administer your billing. As of the print date of this census, these are the Participants and their coverages and costs. This chart defines the items specified in the sample census on page 2. So that the sample statement on page 2 would fit easily in a Word document, we omitted some columns for supplemental coverages.

A	POLICY NUMBER: The assigned policy number for your school district. (This is sometimes referred to as "group ID.")
B	DIVISION: The assigned billing division within your policy number.
C	OUR BILLING ADDRESS. The letters "CB" tell us this is your payment. We have other addresses for correspondence.
D	NAME & ADDRESS: Please confirm that we have the right contact person in the ATTN line for your school address.
E	DUE DATE: The date your premium is due at The Standard.
F	PARTICIPANT ID & NAME: The name and identifying number of the Participant to whom the coverage applies.
G	EFFECTIVE DATE: The date that the Participant became effective for the first coverage.
H	BLIFE (BASIC LIFE): The volume and premium for basic Life coverage.
I	AD&D (BASIC AD&D): The volume and premium for basic Accidental Death and Dismemberment coverage.
J	Other coverages that may be provided by your plan. A column will display and contain information only if at least one Participant has that coverage.
K	PREMIUM TOTAL: The total premium for the Participant.

BILLING CENSUS

THE STANDARD

POLICY NUMBER: CT 123456 A

DIVISION: 1000 B

PLEASE SEND YOUR PREMIUM PAYMENT TO: C

STANDARD INSURANCE COMPANY CB
PO BOX 4664
PORTLAND OR 97208-4664

NAME & ADDRESS: D

AMADOR COUNTY UNIFIED
ATTN SALLY MAY
2425 JEFFERSON STREET
NAPA, CA 97203

PRINT DATE: JAN. 17, 2007

DUE DATE: FEB. 01, 2007 E

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR REMITTANCE AND RETURN THIS PAGE WITH YOUR PAYMENT.
If payment is not received within your contractual grace period, coverage under the contracts will lapse.

Participant Name/ID	Effective Date	BLIFE Volume / Premium	AD&D Volume / Premium	SUPLF Volume / Premium	SAD&D Volume / Premium	SUPPL Volume / Premium	SPADD Volume / Premium	DPLF1 Volume / Premium	DPAD1 Volume / Premium	DIS Volume / Premium	PREMIUM TOTAL
F	G	H	I	J	J	J	J	J	J	J	K
Sullivan, Margaret AA0000064	02/01/07	22,222 $ 9.99	22,222 $ 1.11								$11.10
Subtotal for bill category 0100 Volume		22,222	22,222								
Subtotal for bill category 0100 Premium		$ 9.99	$ 1.11								

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

Appendix A: Annotated Census Bill and Premium Remittance Statement (cont.)

Premium Remittance Statement

After you review the census, make note here of any changes (which typically result from adding or terminating Participants or of increasing coverages) and corresponding adjustments. If you have questions, please call us at 1-800-522-0406. We'd rather talk you through making changes than have you guess.

This chart defines the specified items shown in the sample on page 4.

A	POLICY NUMBER: The assigned policy number for your school district. (This is sometimes referred to as "group ID.")
B	DIVISION: The assigned billing division within your policy number.
C	OUR BILLING ADDRESS. The letters "CB" tell us this is your payment. We have other addresses for correspondence.
D	NAME & ADDRESS: Please confirm that we have the right contact person in the ATTN line for your school address.
E	DUE DATE: The date your premium is due at The Standard.
F	COVERAGE TYPE: The category of insurance for which premium is due.
G	PARTICIPANTS INSURED: This is the **total number** of Participants insured for this coverage type.
H	COVERAGE VOLUME: This is the **total amount** of volume of the Participants insured for this coverage type.
I	RETRO ADJUSTMENTS (+/-): The amount of premium to be added to or deducted from the statement.
J	COVERAGE PREMIUM: Write the ***total premium due*** for all coverages.

THE STANDARD **PREMIUM REMITTANCE STATEMENT**

POLICY NUMBER: CT 123456 A
DIVISION: 1000 B
PRINT DATE: JAN. 17, 2007
DUE DATE: FEB. 01, 2007 E

PLEASE SEND YOUR PREMIUM PAYMENT TO: C

STANDARD INSURANCE COMPANY CB
PO BOX 4664
PORTLAND OR 97208-4664

NAME & ADDRESS: D

AMADOR COUNTY UNIFIED
ATTN SALLY MAY
2425 JEFFERSON STREET
NAPA, CA 97203

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR REMITTANCE AND RETURN THIS PAGE WITH YOUR PAYMENT.
If payment is not received within your contractual grace period, coverage under the contracts will lapse.

BILLING CATEGORY	COVERAGE TYPE	PARTICIPANTS INSURED G	COVERGE VOLUME H	Retro Adjustments (+/-) I	COVERAGE PREMIUM J
0100	BLIFE BASIC LIFE				$
0100	AD&D BASIC AD&D				$
0100	SUPLF SUPPLEMENTAL LIFE				$
0100	SAD&D SUPPLEMENTAL AD&D				$
0100	SUPPL SUPPLEMENTAL PLUS LIFE				$
0100	SPADD SUPPLEMENTAL PLUS AD&D				$
0100	DPLF1 DEPENDENT LIFE				$
0100	DPAD1 DEPENDENT AD&D				$
0100	DPLF2 DEPENDENT LIFE				$
0100	DPAD2 DEPENDENT AD&D				$
0100	DIS DISABILITY				$
				TOTAL PREMIUM DUE. PLEASE PAY THIS AMOUNT ➤	$

Appendix B: Annotated Self-Administered Statement

The Self-Administration Premium Statement contains a summary of Participants, volume of coverage (the total amount of each type of insurance coverage), and the premium due (based on Participants and volume).

Administrators of the self-administered plans complete this statement and send it to Standard Insurance Company (The Standard) with a check in the amount of the calculated premium. The instructions for completing each numbered line are on the back of the statement.

For the samples on pages 2 (the front of the statement) and 3 (the back of the statement), this chart defines the unnumbered items. So that this statement would fit in a Word document, we omitted some of the columns for supplemental coverages. **Only coverages appropriate to your school or organization will have volume, rate, and premium information.** Any other coverage categories can be ignored.

A	POLICY NUMBER: The assigned policy number for your school district. (This is sometimes referred to as "group ID.")
B	DUE DATE: The date your premium is due at The Standard.
C	POLICYOWNER: The contact person and the address for your school. ***Please confirm that this field contains the right information.***
D	NEW MEMBER NAMES: These are the Participants who have been added or whose coverage has increased since your last statement.
E	COVERAGE TYPE: The type of insurance for which you are being billed.
F	COVERAGE AMOUNT OR INSURED EARNINGS: This is the amount of income being protected or the amount of benefit being provided by The Standard's policy.
G	EFFECTIVE DATE: This is the date that the change in the Participant's coverage or coverage amount occurred.
H	TERMINATED MEMBER NAMES: These are the Participants who have been terminated or whose coverage has decreased since your last statement.

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

Appendix B: Annotated Self-Administered Statement (cont.)

STATEMENT OF PREMIUM DUE
PAYABLE ON DUE DATE

POLICY NUMBER A | **DUE DATE** B

POLICYOWNER C

Standard Insurance Company

MAIL CORRESPONDENCE TO:
920 S.W. SIXTH AVE, PORTLAND OR 97204

MAIL PREMIUM PAYMENTS TO:
STANDARD INSURANCE COMPANY CB
PO BOX 4664
PORTLAND, OR 97208-4664

Questions? Call 1-800-522-0406

SEE INSTRUCTIONS ON BACK.

	CURRENT CHANGES OF INSURANCE IN FORCE	BASIC LIFE		BASIC AD&D		ADDITIONAL LIFE		ADDITIONAL AD&D	
		LIVES	VOLUME	LIVES	VOLUME	LIVES	VOLUME	LIVES	VOLUME
1	IN FORCE LAST STATEMENT								
2	ADD NEW MEMBERS *								
3	**ADD VOLUME INCREASES**								
4	LESS TERMINATED MEMBERS *								
5	**LESS VOLUME DECREASES**								
6	**IN FORCE THIS STATEMENT** (1 + 2 + 3 - 4 - 5)								
7	CURRENT PREMIUM RATES								
8	UNADJUSTED PREMIUM (7x6)								
9	BACK CHARGES **								
10	BACK CREDITS **								
11	ADJUSTED PREMIUM (8+9-10)								

* LIST NEW MEMBERS AND TERMINATED MEMBERS ON BACK OF THIS STATEMENT.
** EXPLAIN BACK CHARGES AND BACK CREDITS BELOW.

12	TOTAL PREMIUM (Add line 11 across on all pages.)	
13	CHARGE LAST STATEMENT	
14	CREDIT LAST STATEMENT	
15	PLEASE PAY THIS AMOUNT	

PREPARER'S SIGNATURE

FOR STANDARD INSURANCE COMPANY USE ONLY

SUSPENSE

Appendix B: Annotated Self-Administered Statement (cont.)

New Member Names	Coverage Type	Coverage Amt or Insured Earnings	Effective Date		Terminated Member Names	Coverage Type	Coverage Amt or Insured Earnings	Effective Date
D	E	F	G		H			

INSTRUCTIONS

Line 1	IN FORCE LAST STATEMENT shows the most current in-force figures known to The Standard. Changes in lives or volume received or posted after the calendar month-end may not be reflected on this statement. Verify these figures and change, if necessary.
Line 2	ADDITIONS section of the Enrollment Card File.
Line 3	Enter increases in volume for existing members from the INCREASES section of the Card File.
Line 4	Enter the number of lives and volume of insurance for terminated members from the TERMINATION section of the Card File. Termination by death should be included.
Line 5	Enter decreases in volume for existing members from the DECREASES section of the Card File.
Line 6	Calculate IN FORCE THIS STATEMENT: add Lines 2 and 3 to Line 1 and subtract Lines 4 and 5.
Line 7	Make no changes to CURRENT PREMIUM RATES. If you believe the correct rate is other than that shown, contact your Standard Group Sales Office before completing the statement.
Line 8	Calculate UNADJUSTED PREMIUM: multiply the rate on line 7 by the lives or volume on line 6.
Line 9	Enter back premium charges, if any, which should have been included on a previous statement. (Example: Addition of new members, coverage and volume increases.)
Line 10	Enter any premiums which should be refunded because of overpayments made on a previous statement. (Example: After you remove ineligible members, coverage and volume decrease.)
Line 11	Add Lines 8 and 9 and then subtract Line 10 to determine the ADJUSTED PREMIUM.
Line 12	Add Line 11 across for all coverages to determine the TOTAL PREMIUM.
Line 13	Enter any new charges since the last statement. (Such charges are the result of adding Participants or increasing coverages.)
Line 14	Enter any new credits since the last statement. (Such credits are the result of terminating Participants or decreasing coverages.)
Line 15	Add Lines 12 and 13, and then subtract Line 14 to obtain the amount to be paid. Send a check for the amount on Line 15 with the premium statement.

The information described here is subject to all terms and conditions of the Certificate of Insurance. Please refer to your Certificate of Insurance for full details.

Questions? Call 800.522.0406 or email ctaadmin@standard.com

Glossary

Applicant: An employee applying for coverage, and is not yet insured.

Participant: An employee who is insured under a CTA endorsed plan.

Claimant: An employee who has submitted a claim.