

**CALIFORNIA STATE UNIVERSITY
STANDARD VOLUNTARY INSURANCE
APPLICATION TO CONTINUE
DEPENDENTS LIFE INSURANCE (PORTABILITY)**

INSTRUCTIONS — PLEASE READ CAREFULLY

Continuation Of Insurance

You may continue your Dependents Life Insurance if your Life Insurance ends. However, to be eligible to continue your Dependents Life Insurance, you must meet the following requirements on the date your coverage ends:

1. You are not Totally Disabled.

Dependents may also continue insurance under port provision when they no longer meet the eligibility requirements.

How To Apply

You must apply in writing and pay the first premium to us within 60 days after the date your insurance ends. All questions on these forms must be completed. If you have questions while completing your application, please contact our office at the phone number shown above. You are responsible for making sure all required forms are completed and returned to our office. Processing of your application will begin when your completed form is received by us.

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

- * Any combination of insurance you continue and insurance you convert may not exceed the amount for which you were insured on the date your insurance ends.

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

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

Beneficiary Designation

Benefits payable because of a Dependent's death would be paid to the covered Member. Dependents Life Insurance benefits which are unpaid at the Member's death will be paid in equal shares to the first surviving class of the classes below:

1. The children of the Dependent.
2. The parents of the Dependent.
3. The brothers and sisters of the Dependent.
4. The member's estate.

CALIFORNIA STATE UNIVERSITY STANDARD VOLUNTARY INSURANCE APPLICATION TO CONTINUE DEPENDENTS LIFE INSURANCE (PORTABILITY)

Please type or print. Complete entire form.

IDENTIFICATION	Dependent Spouse/Child Name: _____ (last) (first) (middle)
	Address: _____ (street address)
	_____ (city) (state) (zip code)
	Social Security Number: _____ Telephone No.: () _____
	Birthdate: _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F (mo) (day) (year)

GROUP POLICY	Name of Participating Employer: CALIFORNIA STATE UNIVERSITY
	<input type="checkbox"/> Date Member last worked for the Participating Employer: _____
	<input type="checkbox"/> Employment termination date (if different): _____
	If date Member last worked and employment termination date differ, please explain: _____
Member Social Security No.: _____ Member Name: _____	

ELIGIBILITY	Are you Totally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, you may be entitled to Waiver Of Premium Benefits if you became Totally Disabled while insured under the Group Policy. Check the following box to request Waiver Of Premium claim forms from Standard Insurance Company. <input type="checkbox"/>

AMOUNT	Amount of Dependents Life Insurance you wish to continue (must be in multiples of \$10,000):
	Dependent Spouse \$ _____ Each Child \$ _____
	Any combination of insurance you continue and insurance you convert may not exceed the amount for which you or your dependents were insured on the date your employment terminates.
	Member's birthdate: _____
	Dependent Child(ren) name(s) and birthdate(s): _____
Billing: If approved, you will be billed quarterly (every three months), at your home address. There is an administration fee associated with your continued insurance. Premiums must be received by the due date. There is no grace period for Continuation Of Insurance.	

Please complete reverse side

(continued)

AGREEMENT

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

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

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

Signature of Applicant: _____

Dated: _____