

STANDARD INSURANCE COMPANY

Group Policy Administration
920 SW 6th Avenue
Portland Oregon 97204-1203
(800) 378-4668 x6785
Fax (800) 331-3397

STATE OF OREGON APPLICATION TO CONTINUE OPTIONAL LIFE INSURANCE AND OPTIONAL SPOUSE/DOMESTIC PARTNER LIFE INSURANCE (PORTABILITY) (Group Policy 606814)

INSTRUCTIONS — PLEASE READ CAREFULLY

Continuation Of Insurance

You may continue your Optional Life Insurance and Optional Spouse/Domestic Partner Life Insurance if your employment with your employer terminates. However, to be eligible to continue your Optional Life Insurance and Optional Spouse/Domestic Partner Life Insurance, you must meet the following requirements on the date your employment terminates:

1. You are not Totally Disabled.
2. You are not retired.

If you do not continue your Optional Life Insurance, you may not continue your Optional Spouse/Domestic Partner Life Insurance.

If you elect to continue your Optional Life Insurance you may be able to convert your Optional Life Insurance at a future date.

Continued Insurance is not permanent insurance. Your Continued Insurance may end because, but not limited to, your becoming insured again as a Member under the group policy, regardless of any future premium payments. Please refer to your Certificate for complete information on when Continued Insurance ends.

How To Apply

You must apply in writing and pay the first premium to us within 60 days after your employment termination date. Please include your first quarterly premium with your application. Your application packet has two forms: one for you and one for the employer. 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 both completed forms are received by us.

The amount you may continue is the amount in effect on the date your employment terminates. *You may continue any lesser amount for you or your Spouse/Domestic Partner, in multiples of \$20,000. The amount continued for your Spouse/Domestic Partner may not exceed the amount you continue for yourself. The amount continued will be reduced or terminated according to the Schedule of Insurance in effect on the date your employment terminates. You may not increase the amount you continue.

* Any combination of optional insurance you continue and insurance you convert may not exceed the amount for which you or your spouse were insured on the date your employment terminated.

The initial premium rate will be the rate in effect on the date your employment terminates, 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

Please complete the Beneficiary section of the attached application. If you do not complete the Beneficiary section of the attached application, you will not have a designated beneficiary. In that event, payment of any benefit will be made in accordance with the Beneficiary Provisions of the Group Policy.

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**STATE OF OREGON APPLICATION TO
CONTINUE OPTIONAL LIFE INSURANCE
AND OPTIONAL SPOUSE/DOMESTIC
PARTNER LIFE INSURANCE (PORTABILITY)**

Please type or print. Complete entire form.

IDENTIFICATION	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 State Agency: _____
	Your occupation with the State Agency: _____
	Date you last worked for the State Agency: _____
	Employment termination date (if different): _____
	If date you last worked and employment termination date differ, please explain: _____ _____

ELIGIBILITY	Are you Totally Disabled? <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/>
	Is your employment terminating because of retirement? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

AMOUNT	Amount of Optional Life Insurance you wish to continue for yourself (must be in multiples of \$20,000, not to exceed the amount in effect on the date your employment terminates): \$ _____
	Amount of Optional Spouse/Domestic Partner Life Insurance you wish to continue (must be in multiples of \$20,000; the spouse amount cannot exceed the amount of your continued Optional Life Insurance): Spouse/Domestic Partner \$ _____
	Any combination of optional insurance you continue and insurance you convert may not exceed the amount for which you or your spouse were insured on the date your employment terminates.
	Spouse's/Domestic Partner's birthdate: _____

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)

BENEFICIARY

Full name of your beneficiary:

_____ Relationship _____

Beneficiary's _____

Address _____

If more than one beneficiary is named, benefits will be paid equally unless otherwise designated.

I understand that this designation supersedes any previous beneficiary designation made with respect to my Standard Optional Life Insurance Group Policy 606814.

Your Signature _____ Date _____

AGREEMENT

I hereby apply to continue Optional Life Insurance available through the Standard Insurance Company. I understand I am bound by the terms of the Group Policy 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 understand that if I do not provide the beneficiary designation form on file with my employer or if I do not designate a beneficiary in the Beneficiary section above, payment of any benefit will be made in accordance with the Beneficiary Provisions of the Group Policy.

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, along with the Employer's Statement for continued Group Life Insurance, as the basis for approving this application. I have read and understand the information herein.

Signature of Applicant _____

Dated _____

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**STATE OF OREGON STATE AGENCY'S
STATEMENT FOR CONTINUATION OF
OPTIONAL LIFE INSURANCE
(PORTABILITY)**

Please type or print. Complete entire form.

TO BE COMPLETED BY STATE AGENCY.

Employee's Full Name: _____ Male Female

Employee's Social Security Number: _____ Birthdate: _____

Employee's Occupation: _____

State Agency Name: _____

Is the employee's Optional Life Insurance ending because of employment termination? Yes No

If yes, date of employment termination: _____ Date coverage ends: _____

If no, reason for termination of employee's Optional Life Insurance: _____

Original effective date of coverage:

Employee _____ Spouse _____

Is the employee Totally Disabled? Yes No

Is employment terminating because of retirement? Yes No

Amount of Optional Life Insurance in effect on the date of employment termination:

Employee \$ _____ Spouse \$ _____

PLEASE ATTACH ORIGINAL LIFE ENROLLMENT CARD OR FORM.

I hereby represent that the above information is true and complete to the best of my knowledge.

_____ Date _____ Signature of State Agency Representative

_____ Telephone Number _____ Title

_____ Address