STANDARD INSURANCE COMPANY
Continued Benefits
900 SW Fifth Avenue
Portland OR 97204
Tel (800) 242-1888
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

Portability Of Insurance

You may continue your Optional Life Insurance and Optional Spouse/Domestic Partner Life Insurance under the Portability of Insurance provision of the Group Policy if your employment with your State Agency/University terminates, subject to the following:

1. You must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience on the date your employment terminates.

2. Termination of your employment is not due to retirement.

3. Insurance continued under Waiver of Premium may not be continued under this provision.

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

Insurance continued under this provision is not permanent insurance. It 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 of Insurance for complete information on when insurance continued under this provision 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 State Agency/University. 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 will be reduced or terminated according to the terms of the Group Policy 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/Domestic Partner were insured on the date your employment terminated.

The initial premium rate will be the rate from the table on page 3 based on your or your Spouse/Domestic Partner's age on the date your employment terminates. 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 of Insurance. 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 provide us with the beneficiary designation form on file with your State Agency/University. If you cannot provide that form or if you wish to change your beneficiary designation, please complete the Beneficiary section of the attached application. If we do not receive the form and 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.

Reset

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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: ☐ M ☐ F
(mo) (day) (year)

GROUP POLICY

Name of State Agency/University: _____

Group Policy Number: **606814**

Your occupation with the State Agency/University: _____

Date you last worked for the State Agency/University: _____

Employment termination date (if different): _____

If date you last worked and employment termination date differ, please explain: _____

_____

ELIGIBILITY

Is your employment terminating due to medical reasons? ☐ Yes ☐ No

Are you able to perform with reasonable continuity the material duties of at least one gainful occupation?
☐ Yes ☐ No

Is your employment terminating because of retirement? ☐ Yes ☐ No

Are you planning to pursue other employment? ☐ Yes ☐ No

AMOUNT

Amount of Optional Employee Life Insurance you wish to continue for yourself (must be in multiples of $20,000):
$ _____

Amount of Optional Spouse/Domestic Partner Life Insurance you wish to continue (must be in multiples of $20,000): $ _____

Spouse's/Domestic Partner's birthdate: _____

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.

Billing: If approved, you will be billed quarterly (every three months) at your home address. Premiums must be received by the due date. There is no grace period for continuation of insurance.

Please complete reverse side *(continued)*

PREMIUM COMPUTATION

Monthly Premium Rates for Member and Spouse per $1,000 of Insurance

Age (as of Jan 1)	Rate
Under 25	$ 0.044
25-29	0.052
30-34	0.067
35-39	0.074
40-44	0.081
45-49	0.126
50-54	0.185
55-59	0.348
60-64	0.540
65-69	1.036
70-74	1.680
75+	1.680

	Member	Spouse
1. Age as of January 1st		
2. Monthly Rate for age from above table		
3. Amount of Insurance		
4. Divide Line 3 by 1,000		
5. Multiply Line 4 by Line 2		
6. Add all amounts in Line 5 to arrive at Monthly Premium Amount	$	
7. **Multiply Line 6 by 3** to arrive at TOTAL QUARTERLY PREMIUM DUE	$	

BENEFICIARY

Primary

Full Name		% of Benefit	Address
Social Security No. *(if known)*	Date of Birth	Telephone No.	Relationship
Full Name		% of Benefit	Address
Social Security No. *(if known)*	Date of Birth	Telephone No.	Relationship

If you complete the % of Benefit boxes above, the total amount for all Primary beneficiaries must add up to 100%.

Contingent

Full Name		% of Benefit	Address
Social Security No. *(if known)*	Date of Birth	Telephone No.	Relationship
Full Name		% of Benefit	Address
Social Security No. *(if known)*	Date of Birth	Telephone No.	Relationship

If you complete the % of Benefit boxes above, the total amount for all Contingent beneficiaries must add up to 100%.

AGREEMENT

I hereby apply to continue Group Life Insurance available through Standard Insurance Company. I understand that 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 State Agency/University 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, and that I meet all eligibility requirements for continued insurance under the Group Policy's Portability Of Insurance provision. I understand that Standard Insurance Company will rely on these statements and this information, along with the State Agency/University's Statement for continued Group Life Insurance, as the basis for approving this application. I have read and understand the information herein.

FRAUD NOTICES

FOR RESIDENTS OF ARKANSAS, DISTRICT OF COLUMBIA, KENTUCKY, LOUISIANA, MAINE, NEW MEXICO, OHIO, OKLAHOMA, TENNESSEE AND 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 FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

FOR RESIDENTS OF MARYLAND, RHODE ISLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Signature of Applicant: _____ Dated _____

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

Please type or print. Complete entire form.

TO BE COMPLETED BY STATE AGENCY/UNIVERSITY

Employee's Full Name: _____ ☐ Male ☐ Female

Employee's Social Security Number: _____ Birthdate: _____

Employee's Occupation: _____

State Agency/University 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/Domestic Partner _____

Is employment terminating due to medical reasons? ☐ 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/Domestic Partner $ _____

PLEASE ATTACH SCREENSHOT OF LIFE ENROLLMENT HISTORY

I hereby represent that the above information is true and complete to the best of my knowledge. In addition, I acknowledge I have read the Fraud Notice on the back of this form.

_____ Date

_____ Signature of State Agency/University Representative

_____ Telephone Number

_____ Title

_____ Address

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