

Standard Insurance Company
Employee Benefits Policy Administration
920 SW 6th Avenue
Portland Oregon 97204-1203
1-888-414-0396 Fax 800-331-3397

**DEPENDENTS ONLY
GROUP LIFE INSURANCE
PORTABILITY FORM
SPOUSE AND CHILDREN
MARICOPA COUNTY**

INSTRUCTIONS - PLEASE READ CAREFULLY

Portability Of Insurance

You may continue your Dependents Life Insurance as shown in the Coverage Features of your Certificate, if it is scheduled to end due to the death of, or divorce by, your Spouse.

If you do not continue your Dependents Life Insurance, you may not continue Dependent Life Insurance for a Child.

The amounts of Insurance you continue cannot be increased. Insurance amounts will be terminated according to the terms of the Group Policy in effect on the date your Insurance would otherwise end.

The maximum amount of Dependents Spouse Life Insurance that may be continued is the lesser of: (1) the amount in effect on the day before the insurance would otherwise end; or (2) \$100,000. The minimum Dependents Life Insurance you may continue is \$1,000. The maximum amount of Dependents Child Life Insurance you may continue is the lesser of: (1) the amount in effect on the day before the insurance would otherwise end; or (2) \$10,000. The minimum amount of Dependents Life Insurance that may be continued is \$1,000.

NOTE: Refer to Right To Convert in your Certificate for information regarding eligibility to convert to an individual life insurance policy. Any combination of Insurance you continue and Insurance you convert may not exceed the amount for which you or your Children were insured on the date of your Spouse's death or divorce.

How To Apply

You must apply in writing and pay the first premium to us within 45 days after the date your Insurance would otherwise end. This packet has two forms: one for you and one for the Policyholder/Employer. All questions on these forms must be completed. If you have questions, 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 will begin when both completed forms are received by us.

Premium rates are shown in the Coverage Features section of your Certificate, and with the exception of rates for Children, are subject to increase with advancing age. Premium rates may be changed by Standard with advance written notice. If approved for Portable Insurance, you will be billed quarterly (every three months), at your home address. Premium must be received by the due date. There is no grace period for Portability Of Insurance premium payment. Checks are to be payable to Standard Insurance Company.

Keep your Certificate. It is your certificate of coverage for your continued insurance under the Portability Of Insurance provision. Please note that Insurance continued under the Portability Of Insurance provision ends automatically on the earliest of:

1. The date you become insured under any other group life insurance plan.
2. For any Child, the date you insure the Child under any other group life insurance plan, or who ceases to be a Child according to the terms of the Group Policy.

Beneficiary Designation

Please provide us with the beneficiary designation form on file with the Policyholder/Employer. If you cannot provide that form, or if you wish to change your beneficiary designation, please complete the Beneficiary section on Page 3. If we do not receive the form and if you do not complete the Beneficiary section on Page 3, 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.

BENEFICIARY

This beneficiary designation: (1) revokes all prior designations, and (2) applies to insurance on your life that you continue under the Portability Of Insurance provision. Insurance on your Children, if any, is payable to you, if living, or as provided under the terms of the Group Policy.

Insurance benefits are only payable to a contingent beneficiary if you are not survived by one or more primary beneficiary(ies). Unless specified otherwise: (1) the insurance benefits will be divided equally between beneficiaries in the same class (primary or contingent), and (2) if a beneficiary predeceases you, the beneficiary's share will be divided equally among surviving beneficiaries of the same class. If no beneficiary (primary or contingent) survives you, payment will be made as provided in the Group Policy.

PRIMARY Full Name	Address	Social Security #	Date of Birth	Relationship
CONTINGENT Full Name	Address	Social Security #	Date of Birth	Relationship

AGREEMENT

I hereby apply to continue Insurance available under the terms of the Group Policy.

I agree that no coverage will take effect until it is approved in writing by Standard Insurance Company. I understand that if my request 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 the Policyholder/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 contained herein 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 have read and understand the information herein.

FRAUD NOTICES

FOR RESIDENTS OF ARKANSAS, DISTRICT OF COLUMBIA, KENTUCKY, LOUISIANA, MAINE, NEW MEXICO, OHIO AND TENNESSEE: 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 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: _____ Dated: _____

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POLICYHOLDER/EMPLOYER STATEMENT FOR PORTABILITY OF INSURANCE

Please type or print. Complete entire form.

TO BE COMPLETED BY POLICYHOLDER/EMPLOYER

Employee's Full Name: _____ Male Female
Employee's Social Security Number: _____ Birthdate: _____
Employee's Occupation: _____
Policyholder Name: **Maricopa County** _____
Employer Name, If Different: _____
Group Policy No.: **645547** _____ Effective Date of Group Policy: _____
Is the employee's Group Life Insurance ending because of employment termination? Yes No
If yes, date of employment termination: _____ Date coverage ends: _____
Date employee last worked: _____
If no, reason for termination of dependent's Group Life Insurance: _____

Original effective date of coverage: Employee _____ Spouse _____
Children _____

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

LIFE INSURANCE

Spouse: \$ _____
Each Child: \$ _____

To your knowledge, is or will the terminating dependent be eligible for any other group life insurance plan? Yes No
If yes, please explain: _____

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. In addition, I acknowledge I have read the Fraud Notice on the back of this form.

By: _____
Signature of Policyowner's Representative

Date: _____

Name and Title: _____
(Please Print)

Telephone Number: _____

Address: _____

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