

Standard Insurance Company

CTA Benefits and Services
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Temporary Leave Continuation of Insurance for CTA-Endorsed Plans

For additional information and forms go to: www.CTAMemberBenefits.org/TheStandard

Use this form if you would like to continue part or all of your insurance coverage while on a leave and not receiving Benefits. Mark all applicable boxes and complete all applicable sections. Please return the completed form to The Standard.

Participant Information * Required fields.

SIC USE ONLY	POLICY NO.	PARTICIPANT ID			
FIRST NAME*	MIDDLE INITIAL	LAST NAME*		PHONE NUMBER*	
MAILING ADDRESS*			CITY*	STATE*	ZIP*
SCHOOL DISTRICT* <i>Please do not abbreviate.</i>					
DATE LAST WORKED*			DATE YOU EXPECT TO RETURN TO WORK*		

Coverage(s) to be Continued *Required*

- ALL COVERAGES**
- Life Insurance with Accidental Death & Dismemberment (AD&D)
- Dependents Life Insurance with AD&D
- Disability Insurance

*Disability Insurance may be continued due to the following reasons **only**: Federal and State Mandated Family Medical Leave Act, working for an institution whose primary purpose is research or development of public education in California, **or** during a strike, lockout or other work stoppage caused by a labor dispute.*

Reason for Continuation *Required*

- Temporary Layoff (1st 90 days max)
- Scheduled leave of absence approved by your Employer (24 month max)
- Strike, Lockout or other work stoppage caused by a labor dispute (6 month max)
- Active Duty in the National Guard or Reserves of the armed forces of the United States within the limits of the United States
- State Mandated Family or Medical Leave Act
- Working for an institution whose primary purpose is research or development of public education in California

Signature Required

I wish to make the choices indicated on this form. I agree that my coverage is subject to the terms and conditions of the Group Policy. I understand that if my insurance cannot be continued, any premium advanced by me will be refunded. I understand that my premium deduction amount will change if my coverage or costs change. This authorization will remain in effect until cancelled by me or by The Standard. I certify that I am a member of California Teachers Association (CTA) and understand that termination of CTA membership will cancel my coverage and deductions.

FRAUD NOTICE: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Participant Signature _____ Date _____