Reset

Standard Insurance Company
CTA Benefits and Services
PO Box 4744 Portland OR 97208
Tel & TTY 800.522.0406 Fax 888.414.0393

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* *Please do not abbreviate.*				
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.

Participant Signature _____ Date _____

Print and Sign