Standard Insurance Company

Continued Benefits
800.378.4668 Tel 800.331.3397 Fax
900 SW Fifth Avenue Portland OR 97204

DBA Blue Valley School District No. 229*
Group Life Portability Insurance Request

INSTRUCTIONS – PLEASE READ CAREFULLY

Portability Of Insurance

You may be eligible to buy portable Group Life Insurance if your coverage ends.

To be eligible, you must meet the following requirements:

1. You must have been continuously insured under your employer's Group Life Insurance plan for at least 12 consecutive months on the date your coverage ends.
2. 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.
3. You must be under age 75 on the date your coverage ends.
4. If you do not buy Life Insurance for yourself, you may not purchase any other insurance coverages.

The minimum and maximum amounts of insurance eligible for Portability Of Insurance are shown in your employer's Group Life Insurance plan. The amounts of insurance you purchase under the Portability Of Insurance provision cannot be increased.

NOTE: Refer to the Right To Convert provision in your employer's Group Life Insurance plan for information regarding eligibility to convert to an individual life insurance policy. The combined amounts of insurance you purchase under the Portability Of Insurance provision and insurance you convert may not exceed the amount for which you or your Dependents were insured on the day before your coverage ends. You may also wish to contact an independent insurance agent to discuss other alternatives.

How to Apply

You must apply in writing and pay the first premium to us within 60 days after the date your coverage ends. This packet has two forms: one for you and one for your employer. **You are responsible for making sure all required forms are completed and returned to our office.** Processing will begin when both fully-completed forms and all applicable enrollment forms are received by us. If you have questions, please contact our office at the phone number shown above.

Premium rates are shown on Page 2 of this request, and are subject to increase with advancing age. Premium rates may be changed by Standard Insurance Company (The Standard) with advance written notice. Approved requests will be billed quarterly (every three months). Checks are to be made payable to The Standard. Premium must be received by the due date.

If your request is approved, you will receive a Group Life Portability Insurance certificate which will provide a complete description of coverage. The Group Life Portability Insurance certificate will contain provisions that will be different from your employer's Group Life Insurance plan.

Please note:

Approved amounts will be reduced or terminated according to the terms of the Group Life Portability Insurance Policy.

Group Life Portability Insurance ends automatically on the earliest of:

1. The date it would otherwise end under the Group Life Portability Insurance Policy.
2. The date the last period ends for which we received the required payment.
3. The date the Group Life Portability Insurance Policy terminates.
4. The date you become a full-time member of the armed forces of any country.
5. For any Spouse Insurance, the date of your divorce or legal separation.
6. For any Dependents Insurance:
   a. The date your portable Life Insurance ends.
   b. The date the Dependent ceases to be a Dependent.
7. Your check will be deposited into a conditional receipts account while your request is pending. This does not constitute approval of your request or waiver of the policy's eligibility requirements. If we determine that you are not eligible for coverage, all funds will be returned to you.

Beneficiary Designation

Beneficiary designations that you made under your employer's Group Life Insurance plan will not apply to Group Life Portability Insurance. If you wish to designate a beneficiary for Group Life Portability Insurance, please complete the Beneficiary section on Page 4. If you do not designate a beneficiary, payment of any benefit will be made in accordance with the Benefit Payment and Beneficiary Provisions of the Group Life Portability Insurance Policy.

*For purposes of coverage information provided in the Group Life Portability Insurance Request, "DBA Blue Valley School District No. 229" means "Unified School District No 229 Johnson County State of Kansas," who is the Policyholder.

Reset

Standard Insurance Company

Continued Benefits
800.378.4668 Tel 800.331.3397 Fax
900 SW Fifth Avenue Portland OR 97204

DBA Blue Valley School District No. 229*
Premium Computation Worksheet

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE

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

Age (on last birthday)	Non-Tobacco Rate	Tobacco Rate
0-34	$ 0.16	$ 0.35
35-39	0.26	0.58
40-44	0.39	0.86
45-49	0.57	1.25
50-54	0.96	2.12
55-59	1.34	2.95
60-64	2.00	5.00
65-69	3.86	9.66
70-74	5.41	13.53
75-79	9.74	24.35
80+	17.53	43.83

	Member	Spouse	Child
1. Age			
2. Monthly Rate for age from above table			$0.16 per $1,000
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 $			

TOTAL PREMIUM DUE

Multiply Line 6 by 3 to arrive at TOTAL QUARTERLY PREMIUM DUE $

Standard Insurance Company

Continued Benefits
800.378.4668 Tel 800.331.3397 Fax
900 SW Fifth Avenue Portland OR 97204

DBA Blue Valley School District No. 229*
Member Statement for Group Life Portability Insurance

Please type or print. **COMPLETE ENTIRE FORM.**

1. MEMBER INFORMATION

Name (last, first, middle)			Sex ☐ Male ☐ Female
Street address	City	State	Zip code
Social Security No.	Telephone	Birthdate (month, day, year)	

2. DEPENDENTS INFORMATION (if applicable)

Spouse name (last, first, middle)	Spouse birthdate (month, day, year)

3. EMPLOYER INFORMATION

Name of group **Unified School District No 229 Johnson County State of Kansas**	Group Number **759071**
Name of employer (if different)	Employer HR Contact and Phone Number
Your occupation with the employer	
Date you last worked for the employer	Employment termination date (if different)
If date you last worked and employment termination date differ, please explain:	

4. ELIGIBILITY

Date you became insured under your Employer's coverage under the Group Policy
Have you been insured under your Employer's group life insurance plan for at least 12 consecutive months? ☐ Yes ☐ No
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 for which you are reasonably fitted by education, training and experience? ☐ Yes ☐ No
Are you under the age of 75 on the date your coverage ends? ☐ Yes ☐ No
Have you or your spouse used tobacco in any form in the last 12 months? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

5. AMOUNT OF INSURANCE COVERAGE REQUESTED

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE	
Member	$
Spouse	$
Children	$

Billing: If approved, you will be billed quarterly (every three months), at your home address. Premium must be received by the due date.

(continued)

6. BENEFICIARY

This beneficiary designation applies to all of your Group Life Portability Insurance.

If you name two or more beneficiaries in a class (primary or contingent): (1) Two or more surviving beneficiaries will share equally, unless you provide for unequal shares. (2) If you provide for unequal shares in a class, and two or more beneficiaries in that class survive, we will pay each surviving beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased beneficiary(ies) to the surviving beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving beneficiary bears to the total shares of all surviving beneficiaries. (3) If only one beneficiary in a class survives, we will pay the total death benefits to that beneficiary.

If no beneficiary (primary or contingent) survives you, payment will be made as provided in the Group Life Portability Insurance Policy.

Insurance on your Spouse or other Dependents, if any, is payable to you, if living, or as provided under the terms of the Group Life Portability Insurance Policy.

Note: If death occurs and a minor is the beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid.

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

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

**Percentage of Benefit Total must equal 100%

7. AGREEMENT

I hereby apply for Group Life Portability Insurance.

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 designate a beneficiary in the Beneficiary section on the preceding page, payment of any benefit will be made in accordance with the Benefit Payment and Beneficiary Provisions of the Group Life Portability Insurance 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. I have read and understand the information herein, including the applicable Fraud Notice below.

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 AND 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	Date

Standard Insurance Company

Continued Benefits
800.378.4668 Tel 800.331.3397 Fax
900 SW Fifth Avenue Portland OR 97204

DBA Blue Valley School District No. 229*
Employer Statement for Group Life Portability Insurance

Please type or print. **ENTIRE FORM MUST BE COMPLETED BY EMPLOYER.**

1. MEMBER INFORMATION

Full name		Sex ☐ Male ☐ Female
Social Security No.	Birthdate	Occupation
Member's Insurance Class, if any, as defined by the Group Policy		

2. EMPLOYER INFORMATION

Group name **Unified School District No 229 Johnson County State of Kansas**	Employer name (if different)
Group number **759071**	Effective date of Employer's coverage under the Group Policy with The Standard

Is the Member's Group Life Insurance terminating because employment is ending? ☐ Yes ☐ No

If yes, date employment ended Date coverage ends

Date Member last worked

If no, reason for termination of Member's Group Life Insurance

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

Original effective date of Member's coverage as your Employee (including with your prior carrier)

3. AMOUNT OF INSURANCE

	GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE	
	Basic	Additional (if applicable)
Member	$	$
Spouse	$	
Children	$	

Member	GROUP LIFE INSURANCE continued under Employer's retirement plan (if applicable)
	$

4. ANNUAL EARNINGS

Annual earnings on the last day of active work
Date of the last pay increase/decrease
Annual earnings prior to the last pay increase/decrease

5. EMPLOYER AUTHORIZATION

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 next page.

Signature of authorized representative	Date
Name and title (please print or type)	
Address **15020 Metcalf Ave, Overland Park, Kansas 66223**	Direct telephone number **913-239-4674**

6. ATTACHMENTS

PLEASE ATTACH COPIES OF ALL LIFE ENROLLMENT FORMS
Note: If enrollment forms are not provided, it may prevent us from approving the request.

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 AND 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.

Print