STANDARD INSURANCE COMPANY
Group Policy Administration
900 SW 5th Avenue
Portland Oregon 97204
(800) 378-4668 x6785
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

Continuation Of Insurance

You may continue your Optional Life Insurance and Optional Spouse/Domestic Partner Life Insurance if your employment with your employer terminates. However, to be eligible to continue your Optional Life Insurance and Optional Spouse/Domestic Partner Life Insurance, you must meet the following requirements on the date your employment terminates:

1. You are not Totally Disabled.

2. You are not retired.

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

If you elect to continue your Optional Life Insurance you may be able to convert your Optional Life Insurance at a future date.

Continued Insurance is not permanent insurance. Your Continued Insurance 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 for complete information on when Continued Insurance 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 employer. 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 Schedule of Insurance 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 were insured on the date your employment terminated.

The initial premium rate will be the rate in effect on the date your employment terminates, and an administrative fee will be added. 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. 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 employer. If you cannot provide that form or it 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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STATE OF OREGON APPLICATION TO CONTINUE OPTIONAL LIFE INSURANCE AND OPTIONAL SPOUSE/DOMESTIC PARTNER LIFE INSURANCE (PORTABILITY)

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: _____

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

Are you Totally Disabled? ☐ Yes ☐ No
If yes, you may be entitled to Waiver Of Premium Benefits if you became Totally Disabled while insured under the Group Policy. Check the following box to request Waiver Of Premium claim forms from Standard Insurance Company. ☐

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

AMOUNT

Amount of Optional Life Insurance you wish to continue for yourself (must be in multiples of $20,000, not to exceed the amount in effect on the date your employment terminates): $ _____

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

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.

Spouse's/Domestic Partner's birthdate: _____

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

Please complete reverse side *(continued)*

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
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%

I understand that this designation supersedes any previous beneficiary designation made with respect to my Standard Voluntary Insurance Trust Group Life Insurance.

Signature _____ Date _____

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 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 on this application are complete and true to the best of my knowledge and belief. I understand that Standard Insurance Company will rely on these statements and this information, along with the Employer's Statement for continued Group Life Insurance, as the basis for approving this application. I have read and understand the information herein.

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 _____

Is the employee Totally Disabled? ☐ 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 $ _____

PLEASE ATTACH SCREENSHOT OF LIFE ENROLLMENT HISTORY

I hereby represent that the above information is true and complete to the best of my knowledge.

_____ Date

_____ Signature of State Agency/University Representative

_____ Telephone Number

_____ Title

_____ Address

Print