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

INDIANA UNIVERSITY STANDALONE AD&D INSURANCE PORTABILITY FORM

INSTRUCTIONS - PLEASE READ CAREFULLY

Portability Of Insurance

You may continue your Standalone Voluntary AD&D Insurance and other insurance eligible for portability as shown in the Coverage Features section of your Certificate, subject to the following:

1. The amount of any Insurance to be continued must have been continuously in effect for at least 12 consecutive months on the date your employment terminates.

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. Termination of your employment is not due to your retirement.

- The maximum amount of Standalone Voluntary AD&D Insurance you may continue is the amount in effect on the date your employment terminates. The minimum amount of Standalone Voluntary AD&D Insurance you may continue is $25,000.
- The maximum amount of Dependents AD&D Insurance you may continue is the amount in effect on the date your employment terminates. The minimum amount of Dependents AD&D Insurance you may continue is $1,000.

How To Apply

You must apply in writing and pay the first premium to us within 31 days after the date your employment terminates. 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 are subject to increase with advancing age. Premium rates may be changed by Standard with advance written notice. If approved, 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. 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 it would otherwise have ended under the Group Policy.

2. The date you become insured under any other group accidental death and dismemberment insurance plan.

3. The date the last period ends for which a premium was paid.

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.

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INDIANA UNIVERSITY STANDALONE AD&D INSURANCE PORTABILITY FORM

Reset

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 Policyholder: **Indiana University**

Name of Employer, if different: _____

Group Policy No.: **135262**

Your occupation with the Policyholder/Employer: _____

★ Date you last worked for the Policyholder/Employer: _____

★ Employment termination date (if different): _____

If date you last worked and employment termination date differ, please explain: _____

_____

ELIGIBILITY

Date you became insured under the Group Policy: _____

Has the amount of Insurance you wish to continue been continuously in effect for at least 12 consecutive months?

Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No Children ☐ 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? ☐ Yes ☐ No

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

Are you planning to pursue other employment? ☐ Yes ☐ No

AMOUNT

You may only continue amounts of Insurance that have been continuously in effect for at least 12 consecutive months on the date your employment terminates. If you do not continue your Standalone Voluntary AD&D Insurance, you may not continue any other insurance that may be eligible for portability under the Group Policy. The maximum amount of Standalone Voluntary AD&D Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $500,000. The minimum amount of Standalone Voluntary AD&D Insurance you may continue is $25,000. The maximum amount of Dependents AD&D Insurance you may continue is the lessor of: (1) the amount in effect on the date your employment terminates or (2) $1,000. The minimum amount of Dependents AD&D Insurance you may continue is $1,000.

STANDALONE VOLUNTARY AD&D INSURANCE

Employee: $ _____ Spouse/Child: $_____

Spouse: $ _____ Each Child: $_____

Billing: If approved, 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.

Please complete reverse side *(continued)*

BENEFICIARY

This beneficiary designation: (1) revokes all prior designations, and (2) applies to basic and additional insurance, if any, on your life that you continue under the Portability Of Insurance provision. A separate designation must be completed for Supplemental Life Insurance, if any. Insurance on your Spouse or other Dependents, 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		% 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

*Percentage of Benefit Total must equal 100%

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, 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, 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: _____ Dated: _____

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INDIANA UNIVERSITY
STANDALONE AD&D INSURANCE
POLICYHOLDER/EMPLOYER STATEMENT

Please type or print. ENTIRE FORM MUST BE COMPLETED BY EMPLOYER. Send form to: IU Human Resources
2709 E. 10th Street STE 321
Bloomington, IN 47408

TO BE COMPLETED BY POLICYHOLDER/EMPLOYER

Employee's Full Name: _____ ☐ Male ☐ Female

Employee's Social Security Number: _____ Birthdate: _____

Employee's Occupation: _____

Policyholder Name: **Indiana University**

Employer Name, If Different: _____

Group Policy No.: **135262** Effective Date of Group Policy: _____

Is the employee's Standalone Voluntary AD&D 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 employee's Standalone Voluntary AD&D Insurance: _____

_____

Original effective date of coverage: Employee _____ Spouse _____

Children _____ _____ _____ _____

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

Standalone Voluntary AD&D
PLAN 1 (BASIC)

Employee: $ _____

Spouse: $ _____

Each Child: $ _____

Amount of Insurance continuously in effect for at least 12 consecutive months:

Standalone Voluntary AD&D
PLAN 1 (BASIC)

Employee: $ _____

Spouse: $ _____

Each Child: $ _____

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

Is employment terminating because of retirement? ☐ Yes ☐ No

To your knowledge, is or will the terminating employee be eligible for any other Standalone Voluntary AD&D 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 Policyholder's Representative

Date: _____ Name and Title: _____
(Please Print)

Telephone Number: _____ Address: _____

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