Standard Insurance Company

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

State of Montana
Group Conversion Packet

Thank you for asking for more information about converting your group term life insurance to individual coverage.

If you are terminating employment due to sickness or injury, please contact your employer to determine eligibility for disability or Waiver of Premium benefits before completing this application for conversion.

If you convert your group insurance coverage, you'll have continued protection with premiums payable to age 100. This policy will accumulate cash value, and will allow you to borrow against the cash value if sufficient. Interest on the policy loan will accrue daily and will be at a fixed rate (subject to policy terms and applicable state law). The policy does not share in dividends.

The amount of insurance you may convert depends on the reason for the cessation of your group insurance coverage. If your group life insurance coverage ended for any reason other than your failure to make a required premium contribution or the termination of the group policy, the maximum amount you can convert is the amount of your life insurance which ended. If your life insurance ended because of the termination or amendment of the group policy, or if your insurance has been reduced, then the amount you can convert may be different. Please refer to your Certificate of Insurance or contact Standard Insurance Company for a full description regarding the amount you may be entitled to convert.

To calculate your premium payments, use the attached Schedule of Rates and worksheet.

To complete the conversion, you must return the enclosed application form and your check for the first premium payment within 31 days after the termination of your group insurance. Your application to convert your insurance may not be valid if received in our office after this 31 day period. If you had group life insurance on your dependents and want to convert their coverage also, please contact us for additional applications. Your former employer or group policyholder must also complete the Employer's Certification and send it to us. This application will be attached to and made part of the policy.

If you have any questions about the application or other conversion options, our office is available to assist you. We look forward to continuing to provide you with life insurance protection.

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State of Montana
Group Conversion Whole Life
Premium Rates

Annual Premium per $1,000*
Form G1.3

Age	Premium
0	18.55
1	18.64
2	18.74
3	18.83
4	18.93
5	19.02
6	19.12
7	19.21
8	19.31
9	19.41
10	19.50
11	19.60
12	19.70
13	19.80
14	19.90
15	20.00
16	21.25
17	21.67
18	21.87
19	22.20
20	22.30
21	22.35
22	22.48
23	22.57
24	22.63
25	22.70
26	22.79
27	22.89
28	23.02
29	23.23
30	23.60
31	24.05
32	24.55
33	25.15
34	25.81
35	26.50

Age	Premium
36	27.25
37	28.00
38	28.86
39	29.90
40	31.00
41	32.25
42	33.75
43	35.32
44	36.75
45	38.50
46	40.32
47	42.25
48	44.45
49	46.75
50	49.08
51	51.74
52	54.50
53	57.60
54	61.00
55	64.70
56	68.62
57	72.80
58	77.40
59	82.20
60	87.60
61	93.53
62	99.94
63	106.22
64	112.85
65	119.75
66	127.02
67	134.77
68	143.01
69	151.88
70	159.21
71	167.08

Age	Premium
72	178.00
73	192.12
74	206.37
75	222.60
76	240.06
77	258.80
78	279.82
79	302.24
80	325.90
81	351.11
82	377.34
83	405.32
84	435.22
85	466.82

*Add $40.00 annual policy fee to final premium. These premium rates are not guaranteed and are subject to change by Standard Insurance Company.

Reset

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State of Montana
Worksheet for Calculating Your Premium

1. Determine the amount of insurance you want to convert.

2. Determine whether you want to pay your premium annually, semi-annually, quarterly or monthly. The less frequently you pay the premium, the lower the rate will be.

3. Find your premium from the chart on page 2. The premium is based on the requested face amount of your policy and your age. **(Please note: If your next birthday is less than 6 months away, add one year to your current age.)**

   Age: _____

4. Calculate your premium:

   a) The number of thousand dollar units of coverage you want. (Example: $50,000 is 50 units.) _____

   b) Rate. Using age listed in no. 3 above, find the premium per $1,000 on the chart (see page 2). **x** _____

   c) Multiply (a) times (b). **=** **$** _____

   d) Add $40.00 annual policy fee. + **$40.00**

   e) This is your annual premium due. **=** **$** _____

   f) If not paying annually, multiply the annual premium in (e) by the applicable pay factor below (select one):

      1. semi-annually .516
      2. quarterly .265
      3. monthly .094

      x _____

   g) This is the premium amount due for the pay frequency you selected (if not annual). (Pay factor in (f) times annual premium in (e).) **=** _____

5. If Paying monthly, please include 2 months premium with your application.

EXAMPLE

1. A 40 year old group insured is converting $50,000 of his/her group coverage to an individual whole life policy of $50,000.
2. The group insured wants to pay premiums monthly.
3. The annual premium rate for a 40 year old is $31.00 for each $1,000 of coverage.
4. Premium calculation (see no. 4 above):
   a) 50 units (50,000 ÷ 1,000)
   b) $31.00 (use age of 40 and find rate on the Whole Life Policy chart)
   c) $1,550.00 ($31.00 x 50)
   d) Add $40.00 annual policy fee
   e) $1,590.00 (total annual premium) ($1,550.00 + $40.00)
   f) x .094 (monthly pay factor)
   g) $149.46 due each month ($1,590.00 x .094)

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State of Montana
Instructions for Completing Application for Group Conversion

Please complete all blanks (except for Federal group insurance conversions, for which date of termination of employment is omitted). It is important to use full given name of insured (not initials) and show the date of birth accurately. If you make any changes on the application, please initial and date the change.

1. Check box to indicate who is converting: **Member, Spouse,** or **Dependent Child**.

2. **Name of Group Policyowner.** Please show complete name of Company, Union, Association, Government Unit, etc. Example: John Doe Manufacturing Company.

3. **Amount of coverage requested.** This amount is to be determined as follows:

   a. It may not exceed the face value of your Group Life Insurance on the date of termination.

   b. If your group life insurance coverage includes a portability option, and you choose to continue a portion of your insurance under that provision, you are eligible to convert only the balance of your Group Life coverage.

4. **Premium Payable.** You must include your first premium with your application. If you are paying monthly, please include two months of premium with your application.

5. **Automatic Premium Loan Provision.** The provision is designed to prevent lapse of your policy in case your premium is not paid by the end of the grace period. As long as the policy has sufficient cash value, an automatic policy loan will be made to pay any premium which has not been paid on time. You will be notified of the loan. It may be repaid within 31 days without interest. The interest rate will be shown in your policy.

6. **Full Name of Beneficiary.** The beneficiary is the person named to receive the death benefit. Unless otherwise requested, any amount payable at the death of the Insured is paid in equal shares to the Primary Beneficiaries, if living, or if none is living, in equal shares to the then surviving Contingent Beneficiaries of highest rank. If no beneficiary is then living, payment is made to the owner or the owner's estate. Please show the full given name for a married woman (Jane L. Doe, not Mrs. John L. Doe).

7. **Signature.** Please sign the form at the bottom. Include your address. If the application is for a dependent child under age 18, the signature of the child's parent is required. If a guardian has been named, the guardian must sign and a copy of the Letters of Guardianship should accompany the application.

8. **Please complete** Taxpayer Identification Number (TIN) Certification on the back of the conversion application.

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State of Montana Application for Conversion of Group Insurance

This application must be completed and signed by the person to be insured. Please print all responses.

IDENTIFICATION

Name of Proposed Insured: *(first, middle, last)*		
Street Address:		
City:	State:	Zip Code:
Telephone:	Birthdate:	
Proposed Insured is: ☐ Group Member ☐ Spouse ☐ Dependent	Sex: ☐ Male ☐ Female	
FOR MINOR INSURED: Give total amount of all other life insurance currently in force on this minor insured: $		

GROUP POLICY

Name of Group Policyowner: **State of Montana**	Group Policy No.: **608088**
Amount of Group Life Insurance on termination date: $	
Member's employment and/or membership terminated on: *(month, day, year)*	

DISABILITY

Are you currently unable to work because of sickness or injury? ☐ Yes ☐ No
If yes, please contact your employer to determine eligibility for disability or waiver of premium benefits.

CONVERSION

Amount of individual coverage requested: $ _____

Do you want automatic premium loan provision? ☐ Yes ☐ No

Premium shall be payable: *(check one)* ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly

Amount paid with this application: $ _____

(Follow instructions in this packet for determining premium amount. Your check must be payable to Standard Insurance Company.)

BENEFICIARY (If the insured is a minor, the beneficiary must be the minor's estate.)

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit *Total must equal 100%*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit *Total must equal 100%*

OWNER

OWNER: The owner of the new policy will be the insured if age 18 or older on the date this application is signed, UNLESS a different owner is named here.

Owner *(if other than insured) (must be 18)*:	Address:
(If the insured is under age 18, the owner must be the child's parent or guardian.)	

This application will be attached to and made part of the policy.

Please complete back of form.

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AGREEMENT

Application is made to Standard Insurance Company, to convert my group coverage to an individual life insurance policy as requested above. I agree that all requests shall be subject to the provisions and conditions of the policy and to the company's usual procedures governing any action taken based on this application. I acknowledge that I have read the fraud notice on page 7 of this form.	
Dated:	Signature of Insured:
Signature of Owner: *(if different from insured)*	Parent's or Guardian's Signature: *(if insured is dependent child)*

ALL APPLICATIONS
Taxpayer Identification Number (TIN) Certification

(APPLICANT **MUST** SIGN AND DATE BELOW, AND GIVE TIN, ON **ALL** APPLICATIONS.)

We are required by law to obtain the following information. Please fill in the owner's social security number (or other TIN). Draw a line through no. 2 only if it is not correct.

Certification – Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because: I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or the IRS has notified me that I am no longer subject to backup withholding.

Date:	Owner's Soc. Sec. or TIN Number:	Applicant/Owner's Signature:

Home Office Only – Item(s) no._____ changed to:

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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.

CALIFORNIA RESIDENTS

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

COLORADO RESIDENTS

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.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

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

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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.

ALL OTHER RESIDENTS

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.

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State of Montana
Employer's Certification for Conversion of Group Life Insurance

To Insured: Please give this form to your employer to complete.
To Employer: Please complete the entire form. Please print or type.

TO BE COMPLETED BY FORMER EMPLOYER

Member's Name:		Social Security Number:
Group Policyowner: **State of Montana**		Policy Number: **608088**
Date of Membership/Hire	Effective Date of Insurance:	Member's Termination Date:

Amount of Group Life Insurance on Termination Date (list amount of each coverage separately):

Basic Insurance $		Additional Insurance $	
Supplemental $		Other (specify) $	
Did This Member Have Dependent Coverage? ☐ Yes ☐ No			
Please Indicate the Amount of Dependent Coverage: Spouse $		Child $	

Member's Insurance Class, as Defined by the Policy:

Reason for Termination:

Monthly Salary on Termination Date: $ per month

Effective Date of Last Salary Change:

Was a Summary Plan Description or Certificate of Insurance Delivered to the Member? ☐ Yes ☐ No

Please attach original enrollment/beneficiary card. This is required.

I hereby certify that _____ was an insured Member under the above Group Policy and was insured for the coverage amounts noted above. I acknowledge that I have read the fraud notice on page 9 of this form.

Signature:	Date:	
Name *(print)* and Title:	Telephone Number: ( )	
Street Address:		
City:	State:	Zip Code:

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WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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