The Standard Life Insurance Company of New York

800.378.4668 Tel 800.331.3397 Fax
920 SW Sixth Avenue Portland OR 97204-1203

Notice of Option to Continue Group Life Insurance/Portability Of Insurance Application

INSTRUCTIONS - PLEASE READ CAREFULLY

Portability Of Insurance Notice

You may continue your Life Insurance and other insurance eligible for portability as shown in your Certificate if your employment with the Employer terminates. If you do not continue your Life Insurance, you may not continue any other Insurance.

The minimum and maximum amounts of Insurance eligible for Portability Of Insurance are shown in your Certificate. The amounts of Insurance you continue cannot be increased. Insurance amounts will be reduced or terminated according to the terms of the Group Policy in effect on the date your employment terminates.

The maximum amount of Life Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $300,000. The minimum amount of Life Insurance you may continue is $25,000.

NOTE: Refer to Right To Convert in your Certificate for information regarding eligibility to convert to an individual life insurance policy. The amount of Insurance you continue will be reduced by any amount of Insurance you convert.

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. 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 your Certificate, and are subject to increase with advancing age. Premium rates may be changed by The Standard Life Insurance Company of New York 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 The Standard Life Insurance Company of New York.

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 end under the Group Policy.
2. The date you become insured under any other group life insurance plan.
3. For any Dependent, the date you insure the Dependent under any other group life insurance plan.

Beneficiary Designation

Please provide us with the beneficiary designation form on file with the Policyholder. 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.

Reset

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Group Life Insurance Portability Application

Please type or print. Complete entire form.

IDENTIFICATION

Name of Proposed Insured: *(last, first, middle)*		
Street Address:		
City:	State:	Zip Code:
Social Security Number:	Telephone:	
Birthdate:	Sex: ☐ Male ☐ Female	

GROUP POLICY

Name of Policyholder:	
Name of Employer, if different:	
Group Policy No.:	
Your occupation with the Policyholder:	
⋆ Date you last worked for the Policyholder:	⋆ Employment termination date (if different):

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.

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

_____

Date Notice of Option to Continue Your Insurance Under Portability Of Insurance was given: _____

ELIGIBILITY

Date you became insured under the Group Policy: _____

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

AMOUNT

You may only continue amounts of Insurance that were in effect on the date your employment terminates. If you do not continue your Life Insurance, you may not continue any other insurance that may be eligible for portability under the Group Policy. Accidental Death and Dismemberment (AD&D) Insurance may not be continued. The maximum amount of Life Insurance you may continue is the lesser of: (1) the amount in effect on the date your employment terminates; or (2) $300,000. The minimum amount of Life Insurance you may continue is $25,000.

	LIFE INSURANCE		OTHER: _____
	PLAN 1 (BASIC)	PLAN 2 (ADDITIONAL)	
Employee:	$ _____	$ _____	$ _____
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.

(continued)

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Beneficiary Designation and Agreement

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.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

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.

PRIMARY Full Name	Address	Social Security #	Date of Birth	Relationship
CONTINGENT Full Name	**Address**	**Social Security #**	**Date of Birth**	**Relationship**

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 The Standard Life Insurance Company of New York. 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, 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.

Signature: _____

Dated_____

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Policyholder/Employer Statement for Portability Of Insurance

Please type or print. Complete entire form.

TO BE COMPLETED BY POLICYOWNER/EMPLOYER

Employee's Full Name:	Sex: ☐ Male ☐ Female	Birthdate:
Employee's Social Security Number:	Employee's Occupation:	
Policyholder Name:	Employer Name if different:	
Group Policy No.:	Effective Date of Group Policy:	

Is the employee's Group Life 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 Group Life Insurance: _____

_____

Date Notice of Option to Continue Life Insurance Under Portability Of Insurance was given: _____

Original effective date of coverage: Employee _____ Spouse _____

Children _____ _____ _____ _____

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

	LIFE INSURANCE		OTHER: _____
	PLAN 1 (BASIC)	PLAN 2 (ADDITIONAL)	
Employee:	$ _____	$ _____	$ _____
Spouse:	$ _____	$ _____	$ _____
Each Child:	$ _____		

To your knowledge, is or will the terminating employee be eligible for any other group life 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.

By: _____
Signature of Policyholder's Representative

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

Telephone Number: _____ Address: _____

Print and Sign