

# Supplemental Health Portability\* Request – Employee

ReliaStar Life Insurance Company, Minneapolis, MN  
A member of the Voya® family of companies  
New Business, PO Box 122, Minneapolis, MN 55440-0122  
Voya Employee Benefits Customer Service: 877-236-7564



\*known as "Extension" in some states

## TO BE COMPLETED BY EMPLOYER / ADMINISTRATOR

Notification Date \_\_\_\_\_ Date Due \_\_\_\_\_

## INSTRUCTIONS

**Employer:** Complete designated employer sections. Send this form to the employee along with proof of enrollment coverage amount(s)<sup>1</sup>, and rates and EFT directions.

**Employee:** Refer to your certificate(s) for eligibility. Complete the employee section(s) below. Return the form to the address shown along with proof of enrollment coverage amount(s)<sup>1</sup>. **Coverage will not be continued without this information.** We must receive this information within **31 days** of when your coverage would otherwise terminate.

<sup>1</sup> Examples are Application, Enrollment Form or Enrollment Summary.

## THIS SECTION TO BE COMPLETED BY EMPLOYER / ADMINISTRATOR

Employer or Group Name Bibb County Public Schools Group Number 663646

Account Number 0002 Location \_\_\_\_\_ Class \_\_\_\_\_

Employee Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

SSN \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Hire \_\_\_\_\_

Employment Termination Date \_\_\_\_\_ Coverage Termination Date \_\_\_\_\_

For Critical Illness only:

Employee Coverage Effective Date \_\_\_\_\_ Spouse Coverage Effective Date \_\_\_\_\_

I certify that the above information is true and correct according to the employer's records.

Employer Representative Printed Name \_\_\_\_\_ Contact Phone (\_\_\_\_\_) \_\_\_\_\_

 Employer Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

## THIS SECTION TO BE COMPLETED BY EMPLOYEE

Street Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Insured Spouse Information (if applicable)**

Spouse Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

SSN \_\_\_\_\_ Birth Date \_\_\_\_\_

## TOBACCO USE INFORMATION

Has the Employee used tobacco in any form in the last 12 months? . . . . .  Yes  No

Has the Spouse of the Employee used tobacco in any form in the last 12 months? . . . . .  Yes  No

**PORTABILITY REQUEST**

Coverage cannot be increased. Plan design rules apply. Refer to your certificate(s) and riders for plan information.

	<i>This section to be completed by Employer/Administrator</i>	<i>This section to be completed by Employee</i>
<b>Insurance Coverage Type</b>	<b>Coverage amount at termination</b>	<b>Request coverage to continue</b>
Employee Voluntary Critical Illness	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse Voluntary Critical Illness <sup>2</sup>	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children Voluntary Critical Illness <sup>2</sup>	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

	<i>This section to be completed by Employer / Administrator</i>	<i>This section to be completed by Employee</i>
<b>Insurance Coverage Type</b>	<b>Daily benefit amount at termination</b>	<b>Request daily benefit amount to continue</b>
Employee Voluntary Hospital Confinement Indemnity	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse Voluntary Hospital Confinement Indemnity <sup>2</sup>	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children Voluntary Hospital Confinement Indemnity <sup>2</sup>	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<sup>2</sup> The employee must continue the Employee coverage in order to continue Spouse and/or Children coverage.


**PREMIUM DUE**

Premium Due - total premium of all requested coverage(s)	\$ _____
Billing Frequency - Rates have been provided in a quarterly mode. If you want to pay other than quarterly, select one of the billing modes below and multiply as directed. If you do not choose a different billing mode, you will be billed quarterly and you can skip this row.  <input type="checkbox"/> Semi-Annual (multiply Premium Due by 2) <input type="checkbox"/> Annual (multiply Premium Due by 4)	
Total Payment Required with this form	\$ _____

The initial premium rates for continued coverage have been provided to you along with this form. Rates may increase in the future. Upon receipt of initial premium payment, an additional monthly EFT payment option will be available on a go forward basis. If you want to change your billing frequency after the initial premium payment is submitted, contact Voya Employee Benefits Customer Service. Premium payment does not guarantee coverage. If this request for portability is declined by the insurance company, any premium paid will be refunded.

**SIGNATURE**

To the best of my knowledge and belief, the information I have provided on this form is correct.

 Insured Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE: See page 1 for mailing and contact information.**