Supplemental Health Portability* Request – Employee

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
20 Washington Avenue South, New Business, Minneapolis, MN 55401
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)[1], 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)[1]. **Coverage will not be continued without this information.** We must receive this information within **31 days** of when your coverage would otherwise terminate.

[1] *Examples are Application, Enrollment Form or Enrollment Summary.*

THIS SECTION TO BE COMPLETED BY EMPLOYER / ADMINISTRATOR

Employer or Group Name Coweta County Board of Education Group Number 310531

Account Number 0001 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

Employee Name ________________________________ Group Number 310531________

PORTABILITY REQUEST

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

Insurance Coverage Type	*This section to be completed by Employer/Administrator* **Coverage amount at termination**	*This section to be completed by Employee* **Request coverage to continue**
Employee Voluntary Critical Illness	$	☐ Yes ☐ No
Spouse Voluntary Critical Illness [2]	$	☐ Yes ☐ No
Children Voluntary Critical Illness [2]	$	☐ Yes ☐ No

Insurance Coverage Type	*This section to be completed by Employer / Administrator* **Indicate Yes or No if coverage is in force at termination**	*This section to be completed by Employee* **Request coverage to continue**
Employee Voluntary Accident	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Voluntary Accident [2]	☐ Yes ☐ No	☐ Yes ☐ No
Children Voluntary Accident [2]	☐ Yes ☐ No	☐ Yes ☐ No

Insurance Coverage Type	*This section to be completed by Employer / Administrator* **Indicate Yes or No if coverage is in force at termination**	*This section to be completed by Employee* **Request coverage to continue**
Employee Voluntary Hospital Confinement Indemnity - Low Plan/$100	☐ Yes ☐ No	☐ Yes ☐ No
Employee Voluntary Hospital Confinement Indemnity - Mid Plan/$200	☐ Yes ☐ No	☐ Yes ☐ No
Employee Voluntary Hospital Confinement Indemnity - High Plan/$300	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Voluntary Hospital Confinement Indemnity [2]	☐ Yes ☐ No	☐ Yes ☐ No
Children Voluntary Hospital Confinement Indemnity [2]	☐ Yes ☐ No	☐ Yes ☐ No

[2] *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. ☐ Semi-Annual *(multiply Premium Due by 2)* ☐ 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.