Supplemental Health Portability* Request – Spouse

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. The insured spouse may request to continue coverage in the event of divorce or death of the employee. If so, send this form to the insured spouse along with proof of enrollment coverage amount(s)[1], and rates and EFT directions.

Spouse: If the employee divorces, the insured former spouse may request to continue spouse coverage. If the employee dies, the insured spouse may request to continue spouse and children coverage. See the rider(s) for more information. Complete the spouse 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 form within **31 days** of the divorce or death of the employee.

[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 _____

Spouse Coverage Termination Date _____

For Critical Illness only:
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 SPOUSE

Spouse Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Street Address _____ Phone (_____)_____

City _____ State _____ ZIP _____

SSN _____ Birth Date _____ Date of employee death or divorce _____

SPOUSE TOBACCO USE INFORMATION

Have you 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 Spouse* **Request coverage to continue**
Spouse Voluntary Critical Illness	$	☐ 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 Spouse* **Request coverage to continue**
Spouse Voluntary Accident	☐ 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* Spouse **Request coverage to continue**
Spouse Voluntary Hospital Confinement Indemnity - Low Plan/$100	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Voluntary Hospital Confinement Indemnity - Mid Plan/$200	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Voluntary Hospital Confinement Indemnity - High Plan/$300	☐ Yes ☐ No	☐ Yes ☐ No
Children Voluntary Hospital Confinement Indemnity [2]	☐ Yes ☐ No	☐ Yes ☐ No

[2] If a widowed spouse is requesting continuation due to the death of the employee, then Spouse coverage must be continued in order to continue 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 Spouse Signature _____ Date _____

NOTE: See page 1 for mailing and contact information.