VOYA FINANCIAL

Compass Portability Request

ReliaStar Life Insurance Company

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. The insured spouse may apply to continue coverage in the event of divorce or death of employee. If so, send this form to the insured spouse along with proof of enrollment coverage amount(s)[1] and rates.
***Employee*:** Complete the employee/spouse section(s), as applicable. 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.
Spouse: If the employee divorces, the insured former spouse may apply to continue spouse coverage. If the employee dies, the insured spouse may apply to continue spouse and child coverage. Limitations may apply. Complete the spouse section(s), as applicable. 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 employee. Note: The term "spouse" as used in this form includes a domestic partner or civil union partner as described in the certificate(s) of insurance.

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

This section to be completed by Employer/Administrator

Employer or Group Name: Coweta County Board of Education	Group Number: 31053-1	Account Number:	Location:	Class:
Employee Name:	Social Security Number:	Date of Birth:	Date of Hire:	
Employment Termination Date:	Coverage Termination Date:			
I certify that the above information is true and correct according to the employer's records. Printed Name of Employer Representative:			Contact Telephone Number:	
Signature of Employer Representative:			Date:	

This section to be completed by Employee/Spouse

Street:	Telephone Number:	
City:	State:	ZIP:

Insured Spouse Information, if applicable		
Spouse Name:	Social Security Number:	Date of Birth:
Date of employee death or divorce, if applicable:		

Tobacco Use

Employee: Have you used tobacco products of any kind in the last 24 months?	☐ Yes ☐ No
Spouse: Have you used tobacco products of any kind in the last 24 months?	☐ Yes ☐ No

166225-901 (08/22/2014)

Compass Portability Request Continued

Coverage cannot be increased but may be decreased. Plan design rules apply.

Insurance Coverage Type	*This section to be completed by Employer/Administrator* **Coverage Amount at Termination**	*This section to be completed by Employee* **Requested Coverage Amount to Port**
Employee Voluntary Critical Illness	$	$
Spouse Voluntary Critical Illness	$	$
Child Voluntary Critical Illness	$	$

[2] You must port the employee coverage in order to continue the Spouse and/or Child riders, except in the event of divorce or death of employee.

Quarterly Premium Due

Quarterly Premium Due - total premium of all requested coverage(s):	$
Quarterly Billing Charge:	+ $3.50
Total Payment Required with this form:	$

Premium rates for porting coverage have been provided to you along with this form. Rates may increase in the future. Premium payment does not guarantee coverage. If this request for portability is declined the premium will be refunded.

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

Signature of Insured Employee:	Date:
Signature of Insured Spouse, if applicable:	Date:

Mail Completed To

Mail to: ReliaStar Life Insurance Company
20 Washington Avenue South – Route 6999
Minneapolis, MN 55401

Questions? Please call Customer Service at 1-800-955-7736