

**INSTRUCTIONS – PLEASE READ CAREFULLY**

**Portability Of Insurance**

You may be eligible to buy portable Group Life Insurance if your employment with your employer terminates. If your employer's Group Life Insurance plan includes Accidental Death and Dismemberment (AD&D) and/or Dependents Insurance, you may also be eligible to buy those coverages.

To be eligible, you must meet the following requirements:

1. You must have been continuously insured under your employer's Group Life Insurance plan for at least 12 consecutive months on the date your employment terminates.
2. You must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience on the date your employment terminates.
3. You must be under age 65 on the date your employment terminates.
4. If you do not buy Life Insurance for yourself, you may not purchase any other insurance coverages.

The minimum and maximum amounts of insurance eligible for Portability Of Insurance are shown in your employer's Group Life Insurance plan. The amounts of insurance you purchase under the Portability Of Insurance provision cannot be increased.

NOTE: Refer to the Right To Convert provision in your employer's Group Life Insurance plan for information regarding eligibility to convert to an individual life insurance policy. The combined amounts of insurance you purchase under the Portability Of Insurance provision and insurance you convert may not exceed the amount for which you or your Dependents were insured on the day before your employment terminates. You may also wish to contact an independent insurance agent to discuss other alternatives.

**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 your employer. **You are responsible for making sure all required forms are completed and returned to our office.** Processing will begin when both fully-completed forms and all applicable enrollment forms are received by us. If you have questions, please contact our office at the phone number shown above.

Premium rates are shown on Page 2 of this application, and are subject to increase with advancing age. Premium rates may be changed by Standard Insurance Company (The Standard) with advance written notice. Approved applicants will be billed quarterly (every three months). Checks are to be made payable to The Standard. Premium must be received by the due date.

If your application is approved, you will receive a Group Life Portability Insurance certificate which will provide a complete description of coverage. The Group Life Portability Insurance certificate will contain provisions that will be different from your employer's Group Life Insurance plan.

Please note:

Approved amounts will be reduced or terminated according to the terms of the Group Life Portability Insurance Policy.

Group Life Portability Insurance ends automatically on the earliest of:

1. The date it would otherwise end under the Group Life Portability Insurance Policy.
2. The date the last period ends for which we received the required payment.
3. The date the Group Life Portability Insurance Policy terminates.
4. The date you become a full-time member of the armed forces of any country.
5. For any AD&D Insurance:
  - a. The date you reach age 65.
  - b. The date your Life Insurance ends.
6. For any Spouse Insurance, the date of your divorce or legal separation.
7. For any Dependents Insurance:
  - a. The date your portable Life Insurance ends.
  - b. The date the Dependent ceases to be a Dependent.
8. Your check will be deposited into a conditional receipts account while your application is pending. This does not constitute approval of your application or waiver of the policy's eligibility requirements. If we determine that you are not eligible for coverage, all funds will be returned to you.

**Beneficiary Designation**

**Beneficiary designations that you made under your employer's Group Life Insurance plan will not apply to Group Life Portability Insurance.** If you wish to designate a beneficiary for Group Life Portability Insurance, please complete the Beneficiary section on Page 4. If you do not designate a beneficiary, payment of any benefit will be made in accordance with the Benefit Payment and Beneficiary Provisions of the Group Life Portability Insurance Policy.

Standard Insurance Company

800.378.4668 ext. 6785 800.331.3397 Fax  
 920 SW Sixth Avenue Portland OR 97204-1203

Premium Computation Worksheet

**GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE**

Monthly Premium Rates for Member & Spouse per \$1,000 of Insurance			
Age (on last birthday)	Non-Tobacco Rate	Tobacco Rate	
0-34	\$ 0.16	\$ 0.22	
35-39	0.17	0.24	
40-44	0.23	0.34	
45-49	0.39	0.56	
50-54	0.56	0.81	
55-59	0.97	1.38	
60-64	1.47	2.09	
65-69	2.87	3.98	
70-74	4.70	6.31	
75-79	6.99	9.05	
80+	12.82	16.00	

  

	Member	Spouse	Child
1. Age			
2. Monthly Rate for age from above table			\$0.16 per \$1,000
3. Amount of Insurance			
4. Divide Line 3 by 1,000			
5. Multiply Line 4 by Line 2			
6. Add all amounts in Line 5 to arrive at Monthly Premium Amount	\$		

**GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (if applicable)**

Monthly Premium Rate is \$0.04 per \$1,000 of AD&D Insurance	Member Only
a. Amount of Insurance from Line 3	
b. Divide Line a by \$1,000	
c. Multiply Line b by \$0.04 to arrive at Monthly Premium Amount	\$

**TOTAL PREMIUM DUE**

Add Line 6 to Line c above (if applicable)	\$
<b>Multiply by 3</b> to arrive at TOTAL QUARTERLY PREMIUM DUE	\$

Please type or print. **COMPLETE ENTIRE FORM.**

**1. MEMBER INFORMATION**

Name (last, first, middle)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street address	City	State	Zip code
Social Security No.	Telephone	Birthdate (month, day, year)	

**2. DEPENDENTS INFORMATION (if applicable)**

Spouse name (last, first, middle)	Spouse birthdate (month, day, year)
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**3. EMPLOYER INFORMATION**

Name of group	Group Number
Name of employer (if different)	Employer HR Contact and Phone Number
Your occupation with the employer	
Date you last worked for the employer	Employment termination date (if different)
If date you last worked and employment termination date differ, please explain:	

**4. ELIGIBILITY**

Date you became insured under your Employer's coverage under the Group Policy
Have you been insured under your Employer's group life insurance plan for at least 12 consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your employment terminating due to medical reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you under the age of 65 on the date your employment terminates? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or your spouse used tobacco in any form in the last 12 months? Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

**5. AMOUNT OF INSURANCE COVERAGE REQUESTED**

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE		AD&D INSURANCE (if applicable)
Member	\$	\$
Spouse	\$	\$
Children	\$	\$

Billing: If approved, you will be billed quarterly (every three months), at your home address. Premium must be received by the due date.

(continued)

## 6. BENEFICIARY

This beneficiary designation applies to all of your Group Life Portability Insurance and Accidental Death and Dismemberment Insurance, if any.

If you name two or more beneficiaries in a class (primary or contingent): (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.

If no beneficiary (primary or contingent) survives you, payment will be made as provided in the Group Life Portability Insurance Policy.

Insurance on your Spouse or other Dependents, if any, is payable to you, if living, or as provided under the terms of the Group Life Portability Insurance Policy.

**Note:** If death occurs and a minor is the beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid.

### Primary

Full Name	% of Benefit	Address
Social Security No. (if known)	Date of Birth	Relationship
Full Name	% of Benefit	Address
Social Security No. (if known)	Date of Birth	Relationship
Full Name	% of Benefit	Address
Social Security No. (if known)	Date of Birth	Relationship

### Contingent

Full Name	% of Benefit	Address
Social Security No. (if known)	Date of Birth	Relationship
Full Name	% of Benefit	Address
Social Security No. (if known)	Date of Birth	Relationship
Full Name	% of Benefit	Address
Social Security No. (if known)	Date of Birth	Relationship

**7. AGREEMENT**

I hereby apply for Group Life Portability Insurance.

I agree that no coverage will take effect until it is approved in writing by Standard Insurance Company. I understand that if my request is not accepted, any premium advanced by me will be refunded.

I understand that if I do not designate a beneficiary in the Beneficiary section on the preceding page, payment of any benefit will be made in accordance with the Benefit Payment and Beneficiary Provisions of the Group Life Portability Insurance 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. I have read and understand the information herein, including the applicable Fraud Notice below.

**FRAUD NOTICES**

**FOR RESIDENTS OF ARKANSAS, DISTRICT OF COLUMBIA, KENTUCKY, LOUISIANA, MAINE, NEW MEXICO, OHIO AND TENNESSEE:** Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

**FOR RESIDENTS OF COLORADO:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FOR RESIDENTS OF FLORIDA:** Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**FOR RESIDENTS OF PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature

Date

Standard Insurance Company

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 920 SW Sixth Avenue Portland OR 97204-1203

**Employer Statement for Group Life  
 Portability Insurance**

*Please type or print. ENTIRE FORM MUST BE COMPLETED BY EMPLOYER.*

**1. MEMBER INFORMATION**

Full name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No.	Birthdate	Occupation
Member's Insurance Class, if any, as defined by the Group Policy		

**2. EMPLOYER INFORMATION**

Group name	Employer name (if different)
Group number	Effective date of Employer's coverage under the Group Policy with The Standard
Is the Member's Group Life Insurance terminating because employment is ending? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date employment ended	Date coverage ends
Date Member last worked	
If no, reason for termination of Member's Group Life Insurance	
Is employment terminating due to medical reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Original effective date of Member's coverage as your Employee (including with your prior carrier)	

**3. AMOUNT OF INSURANCE**

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE			AD&D INSURANCE (if applicable)
Member	\$ <sup>Basic</sup>	Additional (if applicable)	\$
Spouse	\$		\$
Children	\$		\$

**4. ANNUAL EARNINGS**

Annual earnings on the last day of active work
Date of the last pay increase/decrease
Annual earnings prior to the last pay increase/decrease

**5. EMPLOYER AUTHORIZATION**

I hereby represent that the above information is true and complete to the best of my knowledge. In addition, I acknowledge I have read the Fraud Notice on the next page.

Signature of authorized representative	Date
Name and title (please print or type)	
Address	Direct telephone number

**6. ATTACHMENTS**

**PLEASE ATTACH COPIES OF ALL LIFE ENROLLMENT FORMS**

**Note:** If enrollment forms are not provided, it may prevent us from approving the application.

## **FRAUD NOTICES**

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**FOR RESIDENTS OF COLORADO:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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## Standard Insurance Company

800.378.4668 ext. 6785 Tel 800.331.3397 Fax  
920 SW Sixth Avenue Portland OR 97204-1203

## Group Conversion Packet

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Thank you for asking for more information about converting your group term life insurance to individual coverage.

If you are terminating employment due to sickness or injury, please contact your employer to determine eligibility for disability or Waiver of Premium benefits before completing this application for conversion.

If you convert your group insurance coverage, you'll have continued protection with premiums payable to age 100. This policy will accumulate cash value, and will allow you to borrow against the cash value if sufficient. Interest on the policy loan will accrue daily and will be at a fixed rate (subject to policy terms and applicable state law). The policy does not share in dividends.

The amount of insurance you may convert depends on the reason for the cessation of your group insurance coverage. If your group life insurance coverage ended for any reason other than your failure to make a required premium contribution or the termination of the group policy, the maximum amount you can convert is the amount of your life insurance which ended. If your life insurance ended because of the termination or amendment of the group policy, or if your insurance has been reduced, then the amount you can convert may be different. Please refer to your Certificate of Insurance or contact Standard Insurance Company for a full description regarding the amount you may be entitled to convert.

To calculate your premium payments, use the attached Schedule of Rates and worksheet.

To complete the conversion, you must return the enclosed application form and your check for the first premium payment within 31 days after the termination of your group insurance. Your application to convert your insurance may not be valid if received in our office after this 31 day period. If you had group life insurance on your dependents and want to convert their coverage also, please contact us for additional applications. Your former employer or group policyholder must also complete the Employer's Certification and send it to us. This application will be attached to and made part of the policy.

If you have any questions about the application or other conversion options, our office is available to assist you. We look forward to continuing to provide you with life insurance protection.

Annual Premium per \$1,000\*  
 Form G1.3

Age	Premium
0	18.55
1	18.64
2	18.74
3	18.83
4	18.93
5	19.02
6	19.12
7	19.21
8	19.31
9	19.41
10	19.50
11	19.60
12	19.70
13	19.80
14	19.90
15	20.00
16	21.25
17	21.67
18	21.87
19	22.20
20	22.30
21	22.35
22	22.48
23	22.57
24	22.63
25	22.70
26	22.79
27	22.89
28	23.02
29	23.23
30	23.60
31	24.05
32	24.55
33	25.15
34	25.81
35	26.50

Age	Premium
36	27.25
37	28.00
38	28.86
39	29.90
40	31.00
41	32.25
42	33.75
43	35.32
44	36.75
45	38.50
46	40.32
47	42.25
48	44.45
49	46.75
50	49.08
51	51.74
52	54.50
53	57.60
54	61.00
55	64.70
56	68.62
57	72.80
58	77.40
59	82.20
60	87.60
61	93.53
62	99.94
63	106.22
64	112.85
65	119.75
66	127.02
67	134.77
68	143.01
69	151.88
70	159.21
71	167.08

Age	Premium
72	178.00
73	192.12
74	206.37
75	222.60
76	240.06
77	258.80
78	279.82
79	302.24
80	325.90
81	351.11
82	377.34
83	405.32
84	435.22
85	466.82

\*Add \$40.00 annual policy fee to final premium. These premium rates are not guaranteed and are subject to change by Standard Insurance Company.

# Standard Insurance Company

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## Worksheet for Calculating Your Premium

1. Determine the amount of insurance you want to convert.
2. Determine whether you want to pay your premium annually, semi-annually, quarterly or monthly. The less frequently you pay the premium, the lower the rate will be.
3. Find your premium from the chart on page 2. The premium is based on the requested face amount of your policy and your age. (**Please note: If your next birthday is less than 6 months away, add one year to your current age.**)

Age: \_\_\_\_\_

4. Calculate your premium:

a) The number of thousand dollar units of coverage you want. (Example: \$50,000 is 50 units.) \_\_\_\_\_

b) Rate. Using age listed in no. 3 above, find the premium per \$1,000 on the chart (see page 2). **x** \_\_\_\_\_

c) Multiply (a) times (b). **=** \$ \_\_\_\_\_

d) Add \$40.00 annual policy fee. **+** \$40.00 \_\_\_\_\_

e) This is your annual premium due. **=** \$ \_\_\_\_\_

f) If not paying annually, multiply the annual premium in (e) by the applicable pay factor below (select one):

1. semi-annually .516

2. quarterly .265

3. monthly .094

**x** \_\_\_\_\_

g) This is the premium amount due for the pay frequency you selected (if not annual). (Pay factor in (f) times annual premium in (e).) **=** \_\_\_\_\_

5. If Paying monthly, please include 2 months premium with your application.

### EXAMPLE

1. A 40 year old group insured is converting \$50,000 of his/her group coverage to an individual whole life policy of \$50,000.
2. The group insured wants to pay premiums monthly.
3. The annual premium rate for a 40 year old is \$31.00 for each \$1,000 of coverage.
4. Premium calculation (see no. 4 above):
  - a) 50 units (50,000 ÷ 1,000)
  - b) \$31.00 (use age of 40 and find rate on the Whole Life Policy chart)
  - c) \$1,550.00 (\$31.00 x 50)
  - d) Add \$40.00 annual policy fee
  - e) \$1,590.00 (total annual premium) (\$1,550.00 + \$40.00)
  - f) x .094 (monthly pay factor)
  - g) \$149.46 due each month (\$1,590.00 x .094)

Please complete all blanks (except for Federal group insurance conversions, for which date of termination of employment is omitted). It is important to use full given name of insured (not initials) and show the date of birth accurately. If you make any changes on the application, please initial and date the change.

1. Check box to indicate who is converting: **Member, Spouse, or Dependent Child.**
2. **Name of Group Policyowner.** Please show complete name of Company, Union, Association, Government Unit, etc.  
Example: John Doe Manufacturing Company.
3. **Amount of coverage requested.** This amount is to be determined as follows:
  - a. It may not exceed the face value of your Group Life Insurance on the date of termination.
  - b. If your group life insurance coverage includes a portability option, and you choose to continue a portion of your insurance under that provision, you are eligible to convert only the balance of your Group Life coverage.
4. **Premium Payable.** You must include your first premium with your application. If you are paying monthly, please include two months of premium with your application.
5. **Automatic Premium Loan Provision.** The provision is designed to prevent lapse of your policy in case your premium is not paid by the end of the grace period. As long as the policy has sufficient cash value, an automatic policy loan will be made to pay any premium which has not been paid on time. You will be notified of the loan. It may be repaid within 31 days without interest. The interest rate will be shown in your policy.
6. **Full Name of Beneficiary.** The beneficiary is the person named to receive the death benefit. Unless otherwise requested, any amount payable at the death of the Insured is paid in equal shares to the Primary Beneficiaries, if living, or if none is living, in equal shares to the then surviving Contingent Beneficiaries of highest rank. If no beneficiary is then living, payment is made to the owner or the owner's estate. Please show the full given name for a married woman (Jane L. Doe, not Mrs. John L. Doe).
7. **Signature.** Please sign the form at the bottom. Include your address. If the application is for a dependent child under age 18, the signature of the child's parent is required. If a guardian has been named, the guardian must sign and a copy of the Letters of Guardianship should accompany the application.
8. **Please complete** Taxpayer Identification Number (TIN) Certification on the back of the conversion application.

Standard Insurance Company

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Application for Conversion of  
Group Insurance

This application must be completed and signed by the person to be insured. Please print all responses.

IDENTIFICATION

Name of Proposed Insured: (first, middle, last)		
Street Address:		
City:	State:	Zip Code:
Telephone:	Birthdate:	
Proposed Insured is: <input type="checkbox"/> Group Member <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
FOR MINOR INSURED: Give total amount of all other life insurance currently in force on this minor insured: \$		

GROUP POLICY

Name of Group Policyowner:	Group Policy No.:
Amount of Group Life Insurance on termination date: \$	
Member's employment and/or membership terminated on: (month, day, year)	

DISABILITY

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.

CONVERSION

Amount of individual coverage requested: \$ \_\_\_\_\_  
Do you want automatic premium loan provision?  Yes  No  
Premium shall be payable: (check one)  Annually  Semi-annually  Quarterly  Monthly  
Amount paid with this application: \$ \_\_\_\_\_  
(Follow instructions in this packet for determining premium amount. Your check must be payable to Standard Insurance Company.)

BENEFICIARY\*

Primary Beneficiary:	Relationship:
Address:	
Contingent Beneficiary:	Relationship:
Address:	
* If the insured is a minor, the beneficiary must be the minor's estate.	

OWNER

OWNER: The owner of the new policy will be the insured if age 18 or older on the date this application is signed, UNLESS a different owner is named here.

Owner (if other than insured) (must be 18):	Address:
(If the insured is under age 18, the owner must be the child's parent or guardian.)	

This application will be attached to and made part of the policy.

Please complete back of form.

**AGREEMENT**

Application is made to Standard Insurance Company, to convert my group coverage to an individual life insurance policy as requested above. I agree that all requests shall be subject to the provisions and conditions of the policy and to the company's usual procedures governing any action taken based on this application. I acknowledge that I have read the fraud notice on page 7 of this form.	
Dated:	Signature of Insured:
Signature of Owner: <i>(if different from insured)</i>	Parent's or Guardian's Signature: <i>(if insured is dependent child)</i>

**ALL APPLICATIONS  
 Taxpayer Identification Number (TIN) Certification**

(APPLICANT **MUST** SIGN AND DATE BELOW, AND GIVE TIN, ON **ALL** APPLICATIONS.)

We are required by law to obtain the following information. Please fill in the owner's social security number (or other TIN). Draw a line through no. 2 only if it is not correct.

**Certification** – Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because: I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or the IRS has notified me that I am no longer subject to backup withholding.

Date:	Owner's Soc. Sec. or TIN Number:	Applicant/Owner's Signature:
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Home Office Only – Item (s) no. \_\_\_\_\_ changed to:

Some states require us to provide the following information to you:

**CALIFORNIA RESIDENTS**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO RESIDENTS**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**NEW JERSEY RESIDENTS**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW YORK RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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**Employer's Certification for Conversion  
 of Group Life Insurance**

*To Insured: Please give this form to your employer to complete.*

*To Employer: Please complete the entire form. Please print or type.*

**TO BE COMPLETED BY FORMER EMPLOYER**

Member's Name:		Social Security Number:
Group Policyowner:		Policy Number:
Date of Membership/Hire	Effective Date of Insurance:	Member's Termination Date:
Amount of Group Life Insurance on Termination Date (list amount of each coverage separately):		
Basic Insurance \$	Additional Insurance \$	
Supplemental \$	Other (specify) \$	
Did This Member Have Dependent Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please Indicate the Amount of Dependent Coverage: Spouse \$		Child \$
Member's Insurance Class, as Defined by the Policy:		
Reason for Termination:		
Monthly Salary on Termination Date: \$ _____ per month		
Effective Date of Last Salary Change:		
Was a Summary Plan Description or Certificate of Insurance Delivered to the Member? <input type="checkbox"/> Yes <input type="checkbox"/> No		

*Please attach original enrollment/beneficiary card. This is required.*

I hereby certify that _____ was an insured Member under the above Group Policy and was insured for the coverage amounts noted above. I acknowledge that I have read the fraud notice on page 9 of this form.		
Signature:	Date:	
Name ( <i>print</i> ) and Title:	Telephone Number: (       )	
Street Address:		
City:	State:	Zip Code:

Some states require us to provide the following information to you:

**CALIFORNIA RESIDENTS**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO RESIDENTS**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**NEW JERSEY RESIDENTS**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW YORK RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA RESIDENTS**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

## TRUE PORTABILITY TRUST AND CONVERSION AT A GLANCE

Product	TRUE PORTABILITY TRUST		CONVERSION	
Type of Policy	Term Life Policy		Whole Life Policy	
Eligibility	Members may purchase life portability insurance (including AD&D) on the date their <b>employment terminates</b> . <b>Disabled members are not eligible.</b>		Members may purchase life conversion insurance (not including AD&D) on the date they have a <b>loss in coverage</b> . <b>Employee CAN be Disabled.</b>	
Length of Group Coverage	<b>Does</b> require continuous coverage for <b>12 consecutive months</b> .		<b>DOES NOT</b> require continuous coverage for 12 consecutive months. Members must have coverage in force for <b>at least 1 day</b> .	
Age Limit	Member must be <b>under age 65</b> on date <b>employment terminates</b> .		<b>No age limit</b> .	
Dependent Continuation	Yes, if insured under employer's group plan <b>and</b> member continues Life coverage on self.		Yes, if insured under employer's group plan.	
AD&D Continuation	Yes, if member continues Life coverage. AD&D terminates at age 65.		No AD&D available.	
Eligible Maximum and Minimum	Maximum: Member: \$300,000 Spouse: \$100,000 Child: \$5,000 Minimum: Member: \$10,000 Spouse: \$5,000 Child: \$1,000		Maximum: All: Amount in force on the date coverage terminates to \$1 Million Minimum: Member: \$2,000 Spouse: \$2,000 Child: Contract Specific	
Medical History	Members may request less, but not more coverage than they had in force on the date their employment terminates. No medical history statements are required.		Members may request less, but not more coverage than they had in force on the date their coverage terminates. No medical history statements are required.	
Premium Payment	Initial premium is required at the time of application.		Initial premium is required at the time of application.	
Grace Period	31-day grace period for premium payments, after initial premium payment.		31-day grace period for premium payments, after initial premium payment.	
Rate Increases	<b>Rates increase in 5 year increments.</b>		<b>No rate increases.</b>	
Smoking	Rates are determined by tobacco status.		Rates are <b>NOT</b> determined by tobacco status.	
Conversion Period	Members must apply for portability coverage within 31 days of employment termination (Conversion Periods may vary).		Members must apply for conversion coverage within 31 days after loss of group coverage (Conversion Periods may vary).	
Where to Send Applications:	Please contact The Standard at <b>800-378-4668 ext 6785</b> within <b>31 days</b> of employment termination for a Portability or Conversion Application and for a full description on the amounts you may be entitled to port or convert.		The application materials and initial premium must be submitted to <b>The Standard</b> for processing at: <b>The Standard, Attn: Continued Benefits, 920 SW 6<sup>th</sup> Ave. Portland, OR 97204</b>	