

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 and beneficiary designation form for the accidental death benefit.

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 and beneficiary designation form for the accidental death benefit. **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 VMware, Inc. Group Number 708348

Account Number 0001 Location _____ Class _____

Employee Name (First) _____ (Middle Initial) _____ (Last) _____

SSN _____ Birth Date _____ 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.

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 _____

PORTABILITY REQUEST

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

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

Insurance Coverage Type	<i>This section to be completed by Employer / Administrator</i> Indicate Yes or No if coverage is in force at termination	<i>This section to be completed by Employee</i> Request coverage to continue
Employee Voluntary Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse Voluntary Accident ²	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children Voluntary Accident ²	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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