Supplemental Health Portability* / Minnesota Continuation Request - Spouse / Child

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. Under some group policies, an insured child may request to continue coverage in the event of death of the employee when there is no insured spouse, or when the child no longer meets the definition of child. If so, send this form to the insured child or their legal guardian 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. Under some group policies, the spouse may also continue child coverage for children who would otherwise lose coverage due to the divorce (refer to the Spouse rider(s) for availability). If the employee dies, the insured spouse may request to continue spouse and children coverage. See the rider(s) for more information. Complete the insured person 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 and the first premium payment within **90 days** of the divorce or death of the employee. Note: The term "spouse" as used in this form may include a domestic partner or civil union partner as described in the spouse rider(s) – see the rider(s) for more information.

Child for Minnesota Continuation (under some group policies): Refer to the Children's rider(s) for availability. If the employee dies and there is no insured spouse, an insured child may request to continue child coverage. If an insured child no longer meets the definition of child for a reason other than death or divorce of the employee, the child may request to continue child coverage. Complete the insured person 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 and the first premium payment within **90 days** of the death of the employee or the loss of child eligibility.

[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 _____

Spouse / Child 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 _____

Employee Name _____ Group Number 708348

THIS SECTION TO BE COMPLETED BY INSURED PERSON

Who is requesting Portability / MN continuation with this form? *(Select only one.):*

☐ Spouse for Portability / Minnesota Continuation ☐ Child for Minnesota Continuation

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

SSN _____ Birth Date _____ Date of employee death or divorce *(if applicable)* _____

Date of child's loss of eligibility *(if applicable)* _____

Street Address _____ Phone (_____)_____

City _____ State _____ ZIP _____

Legal Guardian Information if it applies to an insured child requesting MN continuation: *(include documentation of legal guardianship)*

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

Street Address _____ Phone (_____)_____

City _____ State _____ ZIP _____

PORTABILITY OR MINNESOTA CONTINUATION 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 Insured Person* **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 Insured Person* **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* **Daily benefit amount at termination**	*This section to be completed by Insured Person* **Request daily benefit amount to continue**
Spouse Voluntary Hospital Confinement Indemnity	$	☐ Yes ☐ No
Children Voluntary Hospital Confinement Indemnity [2]	$	☐ 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. If a former spouse is requesting Minnesota continuation due to divorce, then Spouse coverage must be continued in order to continue Children coverage.*

Employee Name _____ Group Number 708348

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/MN continuation is declined by the insurance company, any premium paid will be refunded.

SIGNATURES

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

Insured Person's Signature _____ Date _____

Legal Guardian's Signature *(if applicable)* _____ Date _____

NOTE: See page 1 for mailing and contact information.