

# Term Life Coverage Continuation Request



ReliaStar Life Insurance Company  
A member of the ING family of companies  
PO Box 20, Minneapolis, Minnesota 55440

## Instructions

**Employer:** Read the policy/certificate carefully to determine which coverage(s) are eligible for continuation. Complete and sign the first page of this form. Send this form along with copies of original enrollment/application form(s) to the employee to complete. If your plan provides separate policies or certificates for spouses, then employee and spouse information must be completed on separate forms, with the spouse form to be sent along with copies of original spouse enrollment/application form(s) to the spouse to complete.

**Employee (or Spouse):** Complete the employee/spouse section on the second page and return the form to the address shown. Be sure to include copies of enrollment/application form(s) indicating coverage amounts and beneficiary designations as well as your first quarterly premium. **Coverage will not be continued without this information.** We must receive this form within 31 days of the date premium is paid as shown on this form.

## This section to be completed by employer

### Insured Employee (or Spouse) Information

Employer or group name		Policy number(s)	Account number	Date payroll deduction terminated	Annual Salary at Termination
Insured name	Social Security No.	Date of birth	Date of hire	Is direct billing the result of a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Name (if other than insured):					
Date Basic Life effective	Date Basic Life premium paid to	Date Supplemental Life effective	Date Supplemental Life premium paid to		

Coverage type	Coverage Amount at termination	(1) Coverage Amount eligible for continuation	(2) Monthly premium rate per \$1,000	Quarterly premium due (coverage x rate x 3)
Employee Basic Life				
Employee Basic AD&D				
Supplemental Life				
Supplemental AD&D				
Total				

### Dependent Information

Date dependent coverage effective	Date dependent premium paid to	Spouse Name	Spouse Date of Birth	Spouse Social Security No.
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Has your spouse used tobacco products of any kind in the last 12 months?  Yes  No

Coverage type	Coverage Amount at termination	(1) Coverage Amount eligible for continuation	(2) Monthly premium rate per \$1,000 or per unit	Quarterly premium due (coverage x rate x 3)
Dependent Spouse Life				
Dependent Spouse AD&D				
Children Life				
Children AD&D				
Spouse & Children Life (if one rate applicable to both)				
Total				

(1) Coverage at termination limited by the maximum coverage that can be continued.

(2) For supplemental and dependent coverage, premium rates for continuing coverage will typically stay the same as for active employees; however are subject to future increases. For basic life and AD&D, premium rates for continuing coverage will be provided to the employee by the employer.

### Quarterly Premium Due

Quarterly premium due (total of insured employee (or spouse) and dependent premium above)	\$ _____
Quarterly billing charge	+ \$ <b>3.50</b>
Total payment required with this form (Insured + Dependents)	\$ _____

Signature of employer representative	Date	Company telephone number
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**This section to be completed by employee/spouse**

Billing address (*Street, city, state, zip*)

Enclosed with this form is my first quarterly premium made payable to ReliaStar Life Insurance Company. I hereby authorize ReliaStar Life to begin billing me directly for my Term Life Insurance coverage.

Have you used tobacco products of any kind in the last 12 months?  Yes  No

Date

Your signature

Mail to: ReliaStar Life Insurance Company  
Route 6971  
20 Washington Avenue South  
Minneapolis, Minnesota 55401

**QUESTIONS? Call Worksite Administration at: 1-800-955-7736.**

**This section to be completed by ReliaStar Life**

Date received	Renewal date	Group number	Certificate number	Date mailed
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