Short Term Disability Income Insurance Portability* Request

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
New Business, PO Box 122, Minneapolis, MN 55440-0122
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 the rates and EFT directions.

Employee: Refer to your certificate(s) for eligibility. Complete the Employee section(s) below. Return the form to the address shown above. **Coverage will not be continued without this information.** We must receive this information within **31 days** of when your coverage would otherwise terminate.

THIS SECTION TO BE COMPLETED BY EMPLOYER / ADMINISTRATOR

Employer or Group Name TrueBlue, Inc. Group Number 717690

Account Number _____ Location _____ Class _____

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

SSN _____ Birth Date _____ Date of Hire _____

Employment Termination Date _____ Coverage Termination Date _____

Indicate Yes or No if coverage is in force at termination ☐ Yes ☐ No

Coverage Amount at Termination _____

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 _____

Employee Name _____ Group Number 717690

PORTABILITY REQUEST

Coverage cannot be increased but it can be decreased. Plan design rules apply. Refer to your certificate(s) and riders for plan information including portability duration.

Insurance Coverage Type	*This section to be completed by Employee* **Request coverage to continue**
Short Term Disability Income Insurance	☐ I request to continue coverage. Current coverage amount: _____ ☐ I request to reduce coverage amount to: _____ Refer to the rate sheet for additional information.

PREMIUM DUE

Total Short Term Disability Income Insurance Premium Due	$
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 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.