IMPORTANT: This is a fixed indemnity policy,
NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Supplemental Health Portability* Request – Employee

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 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 TrueBlue, Inc. Group Number 717690

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 _____

Order #207370 11/5/2019

Employee Name _____ Group Number 717690

PORTABILITY 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 Employee* **Request coverage to continue**
Employee Voluntary Critical Illness	$	☐ Yes ☐ No
Spouse Voluntary Critical Illness [2]	$	☐ 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 Employee* **Request coverage to continue**
Employee Voluntary Accident - Low Plan	☐ Yes ☐ No	☐ Yes ☐ No
Employee Voluntary Accident - High Plan	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Voluntary Accident [2]	☐ Yes ☐ No	☐ Yes ☐ No
Children Voluntary Accident [2]	☐ Yes ☐ No	☐ 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 Employee* **Request coverage to continue**
Employee Voluntary Hospital Confinement Indemnity - Low Plan $100 daily benefit	☐ Yes ☐ No	☐ Yes ☐ No
Employee Voluntary Hospital Confinement Indemnity - Standard $300 daily benefit	☐ Yes ☐ No	☐ Yes ☐ No
Employee Voluntary Hospital Confinement Indemnity - Preferred $500 daily benefit	☐ Yes ☐ No	☐ Yes ☐ No
Spouse Voluntary Hospital Confinement Indemnity [2]	☐ Yes ☐ No	☐ Yes ☐ No
Children Voluntary Hospital Confinement Indemnity [2]	☐ Yes ☐ No	☐ Yes ☐ 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. ☐ 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.