RESET FORM

TERM LIFE COVERAGE CONTINUATION REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya™ family of companies
PO Box 20, Minneapolis, MN 55440

VOYA FINANCIAL™

Instructions

Employer: Read the policy/certificate carefully to determine which coverage(s) are eligible for continuation. Complete and sign 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/SPOUSE INFORMATION

Employer/Group Name **State of North Carolina**

Policy Number _____ Account Number _____

Payroll Deduction Terminated Date _____ Annual Salary at Termination $_____

Insured Name _____

Birth Date _____ SSN _____ Hire Date _____

Is direct billing the result of a disability? . . . . . ☐ Yes ☐ No

Employee Name *(if other than insured)* _____

Voluntary Life Effective Date _____ Date Voluntary 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 Voluntary Life				
			Total	

DEPENDENT INFORMATION

Spouse Name _____

Birth Date _____ SSN _____

Dependent Coverage Effective Date _____ Date Dependent Premium Paid To _____

Has your spouse used tobacco products of any kind in the last 12 months? . . . . . ☐ Yes ☐ No

DEPENDENT INFORMATION *(Continued)*

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)
Dependent Spouse Voluntary Life				
Children Voluntary Life				
			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.

QUARTER PREMIUM DUE

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

Employer Representative Signature _____ Date _____

Phone (_____) _____ Email _____

This section to be completed by employee/spouse.

Billing Address _____

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.

Has you used tobacco products of any kind in the last 12 months? . . . . . ☐ Yes ☐ No

Your Signature _____ Date _____

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 _____