RESET FORM

TERM LIFE COVERAGE CONTINUATION REQUEST

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
Administrative Office:
2N - New Business, 20 Washington Avenue South, Minneapolis, MN 55401

Instructions

Employer: Read the policy/certificate carefully to determine which coverage(s) are eligible for continuation. Complete and sign the unshaded portion of this form. Send to the employee/owner 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 to the spouse to complete.

Employee / Spouse / Owner (person eligible to elect continuation): Complete the shaded portion of this form and return to the address shown below. Be sure to include copies of beneficiary designations as well as your first quarterly premium. **Coverage will not be continued without this information.** This form must be received within 31 days of the date premium is paid as shown on this form.

1. EMPLOYER / GROUP INFORMATION *(This section to be completed by employer.)*

Employer / Group Name _____

Policy Number _____ Account Number _____

Payroll Deduction Terminated Date _____ Annual Salary at Termination $_____

2. INSURED EMPLOYEE / SPOUSE INFORMATION *(This section to be completed by employer.)*

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

Birth Date _____ SSN _____ Phone (_____)_____

Hire Date _____ Payroll Deduction Terminated Date _____ Annual Salary at Termination $_____

Is direct billing the result of a disability? . . . . . ☐ Yes ☐ No If "Yes," date of disability. _____

Has an Accelerated Benefit claim on this insured been submitted/paid? . . ☐ Yes ☐ No If "Yes," date of the claim. _____

Employee Name *(if other than Insured)* _____

Employee Birth Date *(if other than Insured)* _____ Employee SSN *(if other than Insured)* _____

Basic Life Effective Date _____ Date Basic Life Premium Paid To _____

Supplemental Life Effective Date _____ 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	

3. SPOUSE / CHILDREN INFORMATION *(This section to be completed by employer.)*

Spouse / Children Coverage Effective Date _____ Date Spouse / Children Premium Paid To _____

3. SPOUSE/CHILDREN INFORMATION *(Continued)*

	Name *(First, MI, Last)*	Birth Date	Gender	SSN/TIN
Spouse			☐ M ☐ F	
	Address			Phone ( )
Child #1			☐ M ☐ F	
	Address			Phone ( )
Child #2			☐ M ☐ F	
	Address			Phone ( )
Child #3			☐ M ☐ F	
	Address			Phone ( )

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)
Spouse Life				
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 spouse/children 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.

4. QUARTERLY PREMIUM DUE *(This section to be completed by employer.)*

Quarterly premium due (total of Insured Employee (or Spouse) and Spouse/Children premium above)		$_____
Quarterly billing charge	+	$ **3.50**
Total payment required with this form (Insured + Spouse/Children)		$_____

Employer Representative Signature _____ Date _____

Phone (_____)_____ Email _____

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5. BILLING INFORMATION *(This section to be completed by employee / spouse / owner (person eligible to elect continuation).)*

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 Insurance Company to begin billing me directly for this Term Life Insurance coverage.

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

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

Employee/Spouse/Owner Signature _____ Date _____

Mail to: ReliaStar Life Insurance Company, 2N - New Business, 20 Washington Avenue South, Minneapolis, MN 55401
QUESTIONS? Call Customer Service at: 800-955-7736.

6. HOME OFFICE USE ONLY *(This section to be completed by the Insurer.)*

Date Received _____ Renewal Date _____ Date Mailed _____

Group Number _____ Certificate Number _____