Administration Guide for Dental and Vision Benefits

THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK

ST 1000 NY 10-22

Welcome

Thank you for selecting The Standard Life Insurance Company of New York as the insurance carrier for your group. We're proud to be part of your benefits program and want to do everything we can do to make administration simple.

Keep this administration guide as reference; however, please note that some information in this guide may not apply to your specific policy.

Contact us anytime with questions:

The Standard Life Insurance Company of New York
Group Customer Service
P.O. Box 82622
Lincoln, NE 68501-2622

Phone: 888-396-8641
Fax: 402-467-7338
Monday – Thursday: 7 a.m. – 7 p.m. (CT)
Friday: 7 a.m. – 5:30 p.m. (CT)

Premium payments
Group Customer Service
PO BOX 650804
Dallas, TX 75265-0804

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Forms

The following forms are included in this administration guide and may be duplicated as needed:

- Enrollment/Change/Waiver Form
- Electronic Funds Transfer (EFT) Authorization Form
- Automated Clearing House (ACH) Form

Privacy Notice

The privacy of your personal information is important to us. We are committed to maintaining and protecting its confidentiality. This notice describes how we collect, share and protect your information.

We use your information to provide and administer the products and services you have requested. We also use it for our internal research and analysis. We want you to know that:

- We do not sell or rent the information we have about you to anyone.
- We do not share your information with outside companies for the purpose of selling their products or services to you.
- We only share information about you with others as the law permits or requires.

Information We May Collect and From Whom

We collect your personal information to offer you insurance and financial products and services. The type of information we collect and the extent to which it is used depends on the products and services we provide to you. For example, we may obtain information such as:

- Your name, mailing and email address(es); date of birth, telephone number and Social Security number; your employment history and education; and your assets and income from applications and other forms from you, your employer and others
- Your policy coverage and claims
- Your premiums and payment history from your dealings with us
- Your credit and financial history from other insurance companies, insurance support organizations and consumer reporting agencies that you authorize
- Your medical history including records from medical providers and related entities, third party administrators, insurance support organizations and consumer reporting agencies that you authorize

Information We May Disclose

We may share the types of information described above with others. These disclosures are only made as authorized by you, or as permitted or required by law. For example, disclosures may be made to:

- Agents or brokers who provide our products and services to you
- Service providers who perform business services or functions on our behalf or to serve you
- Employers and their representatives
- Reinsurers, other insurance companies and insurance support organizations for purposes related to insurance and services you may have or apply for
- Others who may have a joint marketing agreement with us, unless state law restricts such use
- Insurance departments or other legal authorities in connection with the regulation of our business or to comply with laws and regulations
- Law enforcement agencies to help prevent fraud or illegal activities
- Authorized persons in response to a subpoena, warrant or other court order
- Others in order to comply with auditing and reporting requirements
- Our affiliates who may provide insurance or financial products and services to you

When information about you is disclosed to others, we expect them to: (a) protect your information; and (b) use the information only for the limited purpose for which it was shared.

Your Rights

We want to make sure that we have accurate information about you. In general, you have the right to review your personal information that we have. You must make your request in writing and provide us with: your full name, your address and your telephone number. If you believe information we have about you is not accurate, you may tell us; and you may inform us in writing of any changes you believe should be made. We will review your request and respond to it accordingly.

Confidentiality and Security

We protect your personal information by:

- Training our employees to safeguard your information
- Restricting access to those employees who need it to provide products or services to you
- Using physical, electronic and procedural safeguards that protect your information from misuse
- Contractually requiring service providers to secure your information in accordance with state and federal laws

Further Information

We may change our privacy policy at any time. We will provide a new notice if we make material changes to our privacy practices. To view the privacy notice online, visit https://www.standard.com/about-standard/legal-privacy. If your relationship with us ends, we will continue to limit disclosures of your information in accordance with our privacy policy.

The notice applies to:

StanCorp Financial Group, Inc.
Standard Insurance Company
StanCorp Investment Advisers, Inc.
Standard Retirement Services, Inc.
The Standard Life Insurance Company of New York
StanCorp Mortgage Investors, LLC
StanCorp Real Estate, LLC
Standard Management, Inc.
StanCorp Equities, Inc.

Please direct inquiries to:

Privacy Notice (C22)
PO Box 711
Portland, OR 97207-0711

To get more information about StanCorp Financial Group, Inc. and its subsidiaries visit www.standard.com.

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Enrollment

Adding Member Coverage

If you participate in eServices, you can go to our website, www.standard.com/eservices, to add member coverage.

If you do not participate in eServices, you should complete the enrollment/change or waiver form, "Enrollment" section and mail or fax it to:

The Standard Life Insurance Company of New York
Group Customer Service
P.O. Box 82622
Lincoln, NE 68501-2622
Fax: 402-467-7338

The completed form or electronic submission must contain the following required information:

A. Name
B. Gender
C. Date of birth
D. Full time date of hire
E. Accurate name of the policyholder or the policy number
F. Election of coverage for dependents
G. Signature of member

Incomplete sections or missing signatures may delay member enrollment.

The employee needs to elect coverage within 31 days of becoming eligible.

The enrollment form is included in this administration guide and may be duplicated as needed.

Note for Section 125 Plans

Employees who do not elect coverage within 31 days of becoming eligible cannot enroll until the next annual election period and may be subject to limited benefits outlined in the "9219 – Limitations" section of the policy. Please review "9060 – Definitions" section of the policy to determine if the late entrant provision applies to your policy. Employees may only enroll 31 days after becoming eligible if there is a change in family status.

You or the member may get the ID card or Certificate of Coverage at standard.com/services or if you have selected print the printed copy will be mailed to you after the member is enrolled. We won't return the original enrollment form. If you need the enrollment form for your records, please make a copy before submitting it.

Members with dental coverage can elect to receive their Explanation of Benefits online instead of waiting for it to come in the mail when they have a claim paid. Members can enroll for this service at www.standard.com/eservices.

Effective Dates for Members

Members

Each employee has the option of being insured and insuring his or her dependents. To elect coverage, the employee will agree in writing to contribute to the payment of insurance premiums. The effective date for each member and his or her dependents is:

1. the date on which the member qualifies for insurance, if the member agrees to contribute on or before that date
2. the date on which the member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance
3. the date we accept the member and/or dependent for insurance when the member and/or dependent is a late entrant. The member and/or dependent will be subject to any limitation concerning late entrants.

Note: Some policies do not allow employees to waive coverage for themselves or their dependents. If dependent waivers are not allowed, the employee must agree in writing to contribute to the payment of the insurance premiums.

Exception to Member Effective Date

If employment is the basis for membership, an employee needs to be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day the employee returns to active service.

Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with the employer on a full time basis at one of the employer's business establishments or at some location to which the business requires travel.

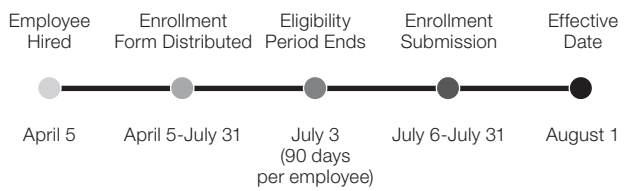
Reinstatement or Rehires

If employment is the basis for membership in the eligible class for members, an insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

Examples:

Date Enrollment Form Signed	Effective Date*
1. on or before eligibility period is satisfied	1. on date eligibility period is satisfied
2. within 31 days after eligibility period is satisfied	2. on date enrollment form is signed
3. over 31 days after eligibility period is satisfied	3. on date enrollment form is signed with late entrant limitations.**

Although eligibility periods vary based on the policy, here is an example of a 90 day eligibility period:



*Some policies are written with first of the month effective dates. For these policies, coverage is effective on the first of the month on or next following the date the member becomes eligible.

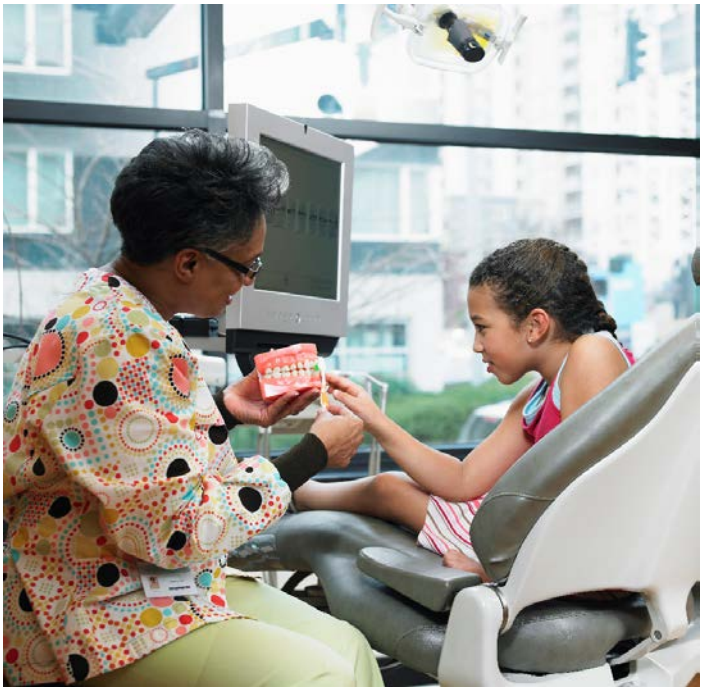
**Late entrant limitations may apply to dental coverage.

Effective Dates for Dependents

Each employee has the option of being insured and insuring his or her dependents.

To elect coverage, the employee agrees in writing to contribute to the payment of the insurance premiums, if required. The effective date for each member, and his or her dependents, will be the first of the month falling on or first following:

1. the date on which the member qualifies for insurance, if the member agrees to contribute on or before that date
2. the date on which the member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance
3. the date we accept the member and/or dependent for insurance when the member and/or dependent is a late entrant. The member and/or dependent will be subject to any limitation concerning late entrants.



Conditions for Eligibility

Members

Requirements for eligibility are defined in the "9070 – Conditions for Insurance Coverage" section of the policy. An example of a requirement may be: "If employment is the basis for membership, a member of the eligible class for insurance is any employee working at least 30 hours per week. If membership is by reason other than employment, then a member of the eligible class for insurance is defined by the policyholder."

The eligibility period or new hire waiting period begins when the member meets the policy's eligibility requirements.

The eligibility period is the length of time that must pass after the member becomes eligible until coverage may become effective.

Dependents

The following are eligible dependents of an insured member:

1. The member's spouse (or domestic partner if this coverage is elected.)
2. Each unmarried child less than the age as defined in the "9060 – Definitions" section of the policy, for whom the insured or the insured's spouse is legally responsible, including:
    A. natural born children
    B. adopted children, eligible from the date of placement for adoption
    C. children covered under a Qualified Medical Child Support Order as defined by applicable federal and state laws
3. Each unmarried child as defined in the "9060 – Definitions" section of the policy who is:
    A. a full time student at an accredited school or college, which includes a vocational, technical, vocational/technical, trade school or institute; and
    B. primarily dependent on the insured or the insured's spouse for support and maintenance.

A divorced spouse is not eligible, but a spouse separated from the employee is eligible.

Review the group policy to identify the specific eligibility requirements for your plan. For clarification you can call our customer service department at 888-396-8641.

Additional Information

For other conditions or exceptions of eligibility, refer to page 12. For continuation of coverage – COBRA, refer to page 18.

Section 125 Eligibility Requirements

General Information

DETAILS ABOUT THE SECTION 125 REQUIREMENTS ARE FOUND AT 26 U.S.C. 125 AND SUPPORTING TREASURY REGULATIONS. PLEASE CONSULT YOUR TAX ADVISOR FOR MORE INFORMATION AND ADVICE REGARDING "CAFETERIA PLANS."

Section 125 of the IRS code allows employees to purchase benefits with pre-tax earnings. These plans are sometimes referred to as "cafeteria plans." The premium is usually paid by the employee although the employer may contribute to the premium. Section 125 plans have an "Annual Election Period" each year for employees to "elect" the benefits they want for the coming plan year. Enrollment or termination is allowed only at:

- New hire satisfaction of the eligibility period
- Election period
- Life event such as:
  - marriage
  - divorce
  - death
  - birth or adoption
  - termination of employment

The annual election period is not an open enrollment. Late entrant penalties apply to any member or dependent with dental only coverage who previously waived or cancelled coverage.

The plan year is any 12 month period for the plan offerings selected by the employer (most common is a calendar year).

Family Status Change

Family status changes allow an employee to make mid-plan year changes in Section 125 plans. Examples include marriage, divorce, birth of a child, death of a spouse or child, and spouse's termination of employment. Refer to Section 125 of the Tax Code and Applicable Treasury Regulations or legal advisor for information regarding family status changes.

Annual Election Period

If an employee does not elect to participate when initially eligible, the employee may elect to participate at the next annual election period. A member may also elect to cancel coverage or reinstate coverage canceled at a previous election period. The election period selected by the Employer is referenced in the "9070 – Conditions for Insurance" section of the policy.

Late entrant limitations will apply to any member or dependent with dental only coverage who previously waived or canceled coverage.

Late Entrant Provision — For Dental Only

A late entrant is a member or dependent who does not enroll within 31 days of becoming eligible or who reinstates coverage after canceling. The benefits available to the late entrant will be limited for the amount of time outlined in the "9219 – Limitations" section of the policy. The premium must be paid continuously during this period and cannot be paid in one lump sum.

**Late entrant limitations may apply to dental coverage.

Change Dependent Coverage

Adding and Removing Dependent Coverage

If you participate in eServices, you can go to www.standard.com, to add member coverage.

If you do not participate in eServices, you should complete the enrollment/change or waiver form, "Enrollment" section and mail or fax it to:

The Standard Life Insurance Company of New York
Group Customer Service
P.O. Box 82622
Lincoln, NE 68501-2622
Fax: 402-467-7338

The completed form or electronic submission needs to contain the following required information:

A. Reason for change (e.g. marriage, divorce, loss of spousal coverage, child reaching the dependent coverage age limitation)

B. The date the dependents qualified for coverage, and/or

C. The date for which the dependent coverage should terminate

Note: As with employees, late enrollments of dependents at the annual election period may result in limited benefits for the time specified in the "9219 – Limitations" section of the policy if the addition is not due to a family status change.

Please review "9060 – Definitions" section of the policy to determine if the late entrant provision applies to your policy.

The enrollment form is included in this administration guide and may be duplicated as needed.

Special Circumstances

Same Employer Spouse Provision

The Same Employer Spouse Provision applies to a spouse who are both employees of the policyholder and have eligible dependent children. Refer to the group policy, "9070 – Conditions for Insurance Coverage" section, to determine if this provision is included in your plan.

This provision allows for one spouse to elect to carry the employee coverage and the other spouse to be covered as a dependent of that employee along with the children. The spouse is covered as a dependent and is not covered as an employee.

Total Disability

Total disability describes the member's dependent as continuously incapable of self-sustaining employment because of mental or physical handicap; and chiefly dependent upon the insured for support and maintenance.

Exception to Dependent Definitions

We may make exceptions to dependent coverage for dependents that are not natural born, adopted, or stepchildren of the member, but meet the age limitation requirements found in the "9060 – Definitions" section of the policy under the following circumstances:

1. The member has legal guardianship of the dependent(s)
2. The dependent is covered by the member's medical carrier
3. The member legally claims the dependent for tax reporting purposes

Update Member Information

We understand that changes to member's personal record information is occasionally necessary.

Examples include:

A. Change or correction to the spelling of a member's name

B. Correction of a date of birth

C. Change of address

D. Correction of a Social Security number or member identification number

Correcting Member Information

1. If you participate in eServices, you can go to www.standard.com/eservices to update member information.
2. If you do not participate in eServices, you can complete the enrollment/change or waiver form, "Change" section and mail or fax it to:

The Standard Life Insurance Company of New York
Group Customer Service
P.O. Box 82622
Lincoln, NE 68501-2622
Fax: 402-467-7338

You may also call our customer service department at 888-396-8641.

Terminate Member Coverage

Notification Procedures

If you participate in eServices, you can go to www.standard.com/eservices to terminate member coverage.

If you do not participate in eServices, you may complete any of the following:

1. List terminated members on page (1) of the premium statement and note the last day worked
2. Draw a line under the member's name on the itemized listing and note the last day worked
3. Call our customer service department at 888-396-8641
4. Complete the enrollment/change or waiver form, "Change" section and note the last day worked and mail or fax it to:

The Standard Life Insurance Company of New York
Group Customer Service
P.O. Box 82622
Lincoln, NE 68501-2622
Fax: 402-467-7338

It is in the policyholder's best interest to report terminations promptly. Without current member eligibility information, we may receive and inadvertently pay a claim for expenses incurred after the termination date. In such cases, we may hold the policyholder liable for additional premium.

Coverage ends as of the date the member ceases to be an eligible member, unless your group policy contains an end of month provision. The termination date excludes accrued vacation time or other benefits. No refund is made when termination occurs in the middle of a policy month. Premium should be paid for the full month.

Some members may be eligible for a continuation of coverage; please refer to pages 18 and 19 for more information.

Note for Section 125 Plans

Employees and/or their dependents, may only terminate coverage at the annual election period unless there is a family status change. If the member drops coverage for a reason other than termination of employment the status change must be reported.

Change Policy Provisions

Policy provisions may need to change from time to time. Examples include:

A. Change of company name

B. Change of eligibility period

C. Change in the number of hours worked to qualify for group coverage

Changing Policy Provisions

1. You should contact your Standard sales representative or broker regarding the policy changes you wish to make. Some changes may require additional underwriting and may affect your current premium rates.
2. You will need to describe the desired change including your requested effective date on your letterhead and have it signed by a person authorized to represent the company and then mail or fax it to:

The Standard Life Insurance Company of New York
Group Customer Service
P.O. Box 82622
Lincoln, NE 68501-2622
Fax: 402-467-7338

Premium Payment

Due Dates

Premium payments are due by the first day of the coverage period, typically a calendar month.

Payment by Check

You should attach a copy of the billing statement with a check payable to The Standard Life Insurance Company of New York and any detail on how you arrived at your payment if manual adjustments were made and mail to:

The Standard Life Insurance Company of New York
Group Customer Service
PO BOX 650804
Dallas, TX 75265-0804

Please call our customer service department at 888-396-8641 if you have not received your statement by the first of the current month. Payments not received by the last day of the grace period will be subject to termination of coverage.

eBill

You can perform many of your billing and payment functions online; please see the eBill portion of the eServices overview on page 20.

Electronic Premium Payment

You may utilize Electronic Funds Transfer (EFT) or Automated Clearing House (ACH) electronic transfers even if you do not participate in eServices. By utilizing one of these electronic payment methods you no longer need to write a check for the premium, and don't have to worry about mailing delays.

Electronic Funds Transfer (EFT)

The EFT will automatically draft the correct amount of premium from your account at the same time each month.

To make payments through EFT.

A. Complete the EFT authorization form attached in this administration guide
B. Attach a copy of a voided check
C. Mail or fax both forms to the address listed below.

Automated Clearing House (ACH)

ACH will allow you to electronically remit funds directly to us. Remember, you will need to mail or fax in documentation on how you arrived at your payment amount each month if different from the total amount billed.

To make payments through ACH:

A. Complete the ACH form attached in this administration guide
B. Mail or fax the form to:

The Standard Life Insurance Company of New York
P.O. Box 82588
Lincoln, NE 68501-2588
Fax: 402-467-7338

Premium Accounting

The total amount due on the front page of the billing statement will reflect any credit balance or balance forward.

The total amount due is determined as follows:

+/ – Any credit/balance forward
– Payment received
+ Current month's premium due for active members
+/ – Retro credit and/or debit adjustments
= Total amount due/check amount

The "9050 – Simplified Accounting" section of the policy states that premium will be due as of the first premium due date falling on or after the date the employee's coverage is effective.

Example

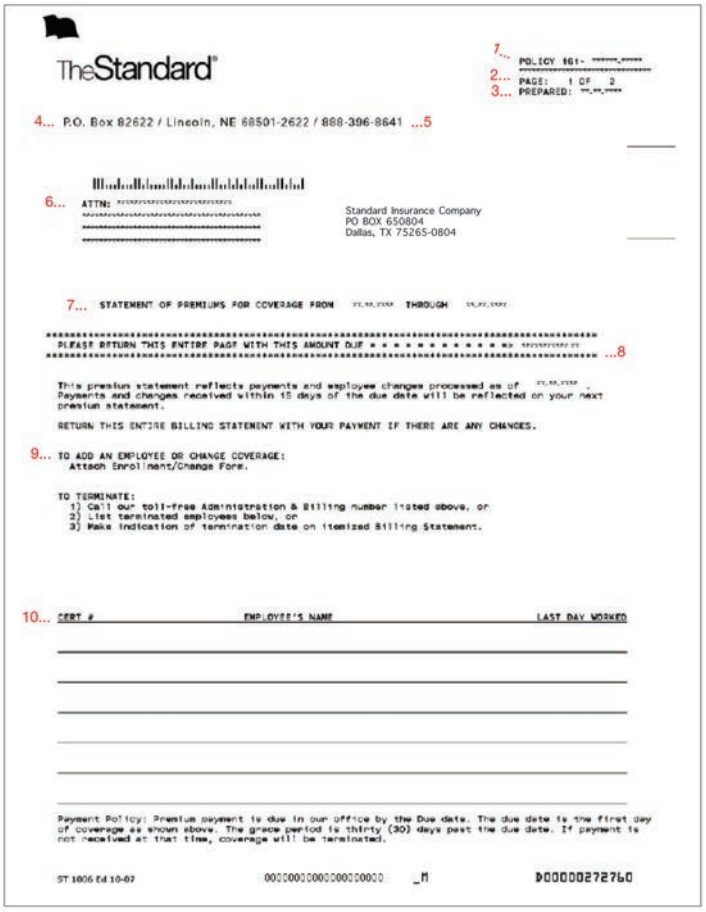
If a member's coverage is effective on January 15 and the premium due date is the first of the month; the first premium due for that member is February 1 (which is the first of the month following the effective date).

Premium will not be prorated for a partial month for members terminated between premium due dates.

From the time you notify us of a retroactive termination, up to three (3) months of unearned premium credit from the most current statement billed may be refunded to you.

It is important to report terminations timely as the policyholder is liable for any benefits released in the period following the termination until we receive the termination information.

Sample Billing Statement


TheStandard®

1... POLICY 161- ******-*****
2... PAGE: 1 OF 2
3... PREPARED: **-**-****

4... P.O. Box 82622 / Lincoln, NE 68501-2622 / 888-396-8641 ...5

6... ATTN: **********
Standard Insurance Company
PO BOX 650804
Dallas, TX 75265-0804

7... STATEMENT OF PREMIUMS FOR COVERAGE FROM **/**/**** THROUGH **/**/****

PLEASE RETURN THIS ENTIRE PAGE WITH THIS AMOUNT DUE ********** ...8

This premium statement reflects payments and employee changes processed as of **/**/**** .
Payments and changes received within 15 days of the due date will be reflected on your next premium statement.

RETURN THIS ENTIRE BILLING STATEMENT WITH YOUR PAYMENT IF THERE ARE ANY CHANGES.

9... TO ADD AN EMPLOYEE OR CHANGE COVERAGE:
Attach Enrollment/Change Form.

TO TERMINATE:
1) Call our toll-free Administration & Billing number listed above, or
2) List terminated employees below, or
3) Make indication of termination date on itemized Billing Statement.

10... CERT # EMPLOYEE'S NAME LAST DAY WORKED

Payment Policy: Premium payment is due in our office by the Due date. The due date is the first day of coverage as shown above. The grace period is thirty (30) days past the due date. If payment is not received at that time, coverage will be terminated.

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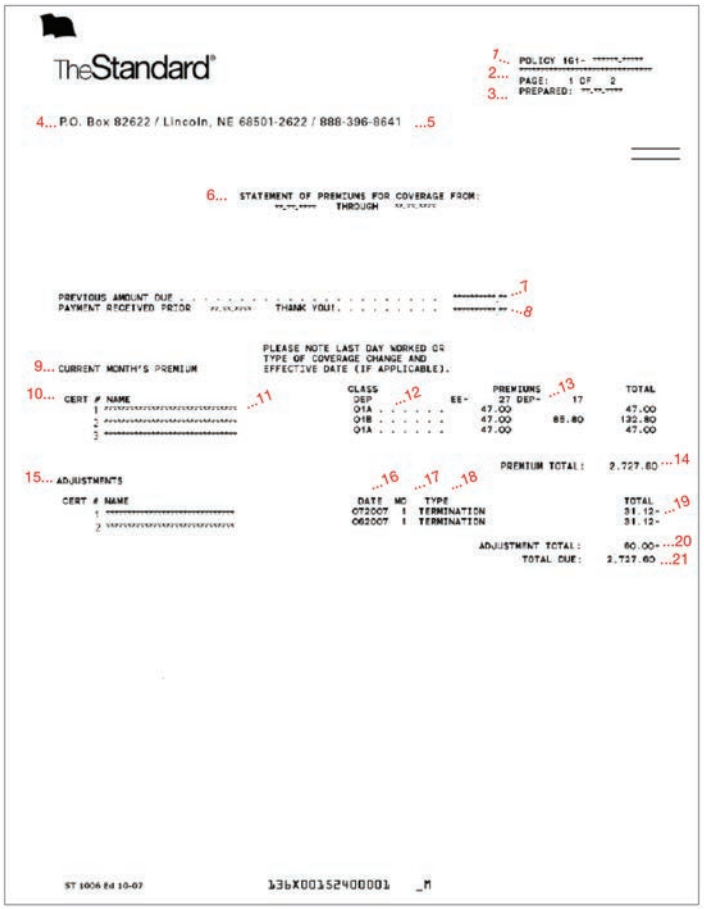
Cover Page of Billing Statement

Return this page with your payment.

1. Policy and Division number.
2. Policy or Division name.
3. Date statement was printed. Payments or adjustments applied on or after this date are not reflected on the statement.
4. Mailing address.
5. Phone number for claims or administrative questions.
6. Billing address.
7. Coverage dates for the premium due. Payments and adjustments received within fifteen days of the beginning date will appear on your next billing statement.
8. Total amount due for this billing statement. PAY THIS AMOUNT.
9. Payment, enrollment, change, and termination information. A billing memo may appear in place of this information.
10. Space to report terminated employees. Please include employee's certificate number, name, and last day worked.

Sample Billing Statement – Continued


TheStandard®

1... POLICY NO:- ******-*****
2... ********** GROUP
3... PAGE: 1 OF 2
PREPARED: **-**-****

4... P.O. Box 82622 / Lincoln, NE 68501-2622 / 888-396-8641 ...5

6... STATEMENT OF PREMIUMS FOR COVERAGE FROM:
--**** THROUGH **-**-****

PREVIOUS AMOUNT DUE . . . . . ********** ...7
PAYMENT RECEIVED PRIOR **-**-**** THANK YOU! . . . . . ********** ...8

9... CURRENT MONTH'S PREMIUM

PLEASE NOTE LAST DAY WORKED OR TYPE OF COVERAGE CHANGE AND EFFECTIVE DATE (IF APPLICABLE).

10... CERT #	NAME ...11	CLASS DEP	...12 EE-	PREMIUMS 27 DEP- ...13 17	TOTAL
1	**********	01A	47.00		47.00
2	**********	01B	47.00	85.80	132.80
3	**********	01A	47.00		47.00

PREMIUM TOTAL: 2,727.60 ...14

15... ADJUSTMENTS

CERT #	NAME ...16	DATE	MO ...17	TYPE ...18	TOTAL ...19
1	**********	07 2007	1	TERMINATION	31.12-
2	**********	06 2007	1	TERMINATION	31.12-

ADJUSTMENT TOTAL: 60.00- ...20
TOTAL DUE: 2,727.60 ...21

ST 1006 Ed 10-07 136X00152400001 _M

Itemization of Billing

Retain For Your Records

1. Policy and Division number.
2. Policy or Division name.
3. Date statement was printed. Payments and changes applied on or after this date are not on this statement.
4. Mailing address.
5. Phone number for claims or administrative questions.
6. Coverage dates for the premium due. Payments and changes received within fifteen days of the beginning date will be on your next billing statement.
7. Amount billed on your last billing statement.
8. Payments received since your last billing statement.
9. Itemization of employees and premiums due for current month only – does NOT include credits or charges for previous months.
10. Employee Certificate number.
11. Employees being billed for current month's premium.
12. Class number (e.g. 01) and dependent coverage code (e.g. A for single coverage).
13. Itemization of current month's premium due on each employee broken out for employee's and dependent's premiums. The numbers directly beside EE and DEP at head of columns list total number listed on current month.
14. Subtotal for current month's premium only – does not include previous month's adjustments or credits and charges carried forward from previous billing statement.
15. Adjustments for previous month's premiums, such as back credits for terminated employee or back premiums for employee enrolled late.
16. Starting month and year for adjustment.
17. Number of months affected by adjustment.
18. What adjustment is for.
19. Itemization of adjustments.
20. Subtotal of adjustments ONLY.
21. Total amount due on this statement. This amount reflects total of #7, #8, #14, #20.

Continuation of Coverage — COBRA

THIS INFORMATION REGARDING CONTINUATION AND COBRA IS PROVIDED FOR YOUR INFORMATION ONLY AND IS NOT LEGAL ADVICE. IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING WHETHER YOUR HEALTH PLAN IS SUBJECT TO COBRA CONTINUATION REQUIREMENTS, OR ANY OTHER QUESTIONS CONCERNING COBRA, YOU SHOULD SEEK THE ADVICE OF LEGAL COUNSEL.

At The Standard Life Insurance Company of New York we do not offer a conversion of group coverage to individual coverage. Federal legislation has provided for a continuation of group dental and vision insurance in the event that coverage terminates under certain qualifying events.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) became law on July 1, 1986. Generally speaking, the law requires a policyholder who employs 20 or more people to provide continuation of health care benefits to employees who lose their coverage due to a qualifying event. Qualifying events include events that cause an employee to lose coverage, such as being laid-off, terminated, retired, fired for reasons other than gross misconduct, etc. The law also allows continuation of benefits to dependents who lose coverage due to death of employee, dependents divorce from employee etc.

The maximum length of continuation coverage available under COBRA for a non-disabled employee is 18 months. The same maximum of 18 months of coverage is available to dependents if the qualifying event is a termination or a reduction in hours. Employees who are disabled according to Social Security rules as of their qualifying date may continue coverage for an additional 11 months after the completion of the 18 months if they continue to be disabled. Up to 36 months of continuation is available to dependents for any other qualifying event. For example, an employee who terminates is eligible for a maximum of 18 months coverage continuation, while a spouse who loses coverage due to a divorce can elect up to 36 months.

Some states have insurance continuation legislation. These state laws, if applicable, would run concurrently with COBRA.

Persons choosing COBRA continuation have 60 days from the date notified of their continuation rights to elect the coverage.

A person under COBRA can add or delete dependent coverage as any other covered employee, but coverage is limited to the extent of the continuation period.

The employee or qualified dependent is responsible for paying for the coverage. The amount charged is based on the same rates charged for active/retired employees and their dependents. The policyholder may add 2 percent of the premium to the rate charged and retain the 2 percent fee for their own administrative expenses. It is the responsibility of the policyholder to collect this premium and remit it to us with the regular premium payment.

Please note that COBRA premiums collected must be included in the payment of premiums for active employees. We do not accept personal checks from the COBRA insureds themselves.

COBRA Enrollment and Termination

THIS INFORMATION REGARDING CONTINUATION AND COBRA IS PROVIDED FOR YOUR INFORMATION ONLY AND IS NOT LEGAL ADVICE. IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING WHETHER YOUR HEALTH PLAN IS SUBJECT TO COBRA CONTINUATION REQUIREMENTS, OR ANY OTHER QUESTIONS CONCERNING COBRA, YOU SHOULD SEEK THE ADVICE OF LEGAL COUNSEL.

In circumstances where a member may elect COBRA, please submit the member's last day worked in the same manner as all other terminations.

Once the member has elected COBRA follow the steps below to reinstate the member retroactive to their termination date. Any claims that were denied during the time period of the termination can be reconsidered provided notification by the provider or member that a claim was denied due to termination of coverage. The provider or member may call our customer service department at 888-396-8641 to notify our representatives that a submitted claim needs reconsideration.

COBRA Enrollment

To enroll a former member or covered dependent for continuation coverage under COBRA, notify us by filling out the COBRA box at the top of the enrollment/change/waiver form.

COBRA Termination

COBRA coverage will cease on the earliest of the following dates:

1. At the end of 18 months for an employee*
2. At the end of 36 months for dependents (except as noted above)
3. The person's failure to pay the premium for coverage
4. The person's becoming entitled to Medicare
5. With respect to a spouse, upon remarrying and becoming insured under another plan

If an insured elects to terminate COBRA coverage, we require that you submit a written notice. Once you have notified us to discontinue COBRA coverage for an employee, the employee may not be reinstated.

*An employee who is disabled according to Social Security rules may be eligible for up to an additional 11 months.

eServices Overview

Our website, www.standard.com allows access to free online services that will make administering your employee benefit plan fast and easy.

eServices is not available for all groups. Please call our customer service department at 888-396-8641 for eligibility requirements.

eEnroll

- Save time by using our website to enroll, change or terminate member coverage in real-time
- View member coverage status including effective dates, dependent coverage levels, and more
- Sign up for eEnroll, and you're eligible for eBill

eBill and Electronic Funds Transfer (EFT)

- Simply order your bill online and pay online
- Update member information before paying
- View online, or print a list billing that shows your detailed adjustments
- Access up to a year of premium information and billing history online

eView

- You can always view member effective dates, dependent coverage levels, and more through our website
- View your policy and certificates

eCert

- Allows you access to important plan documents online
- View your policy and certificates
- Distribute certificates electronically by downloading PDF files to attach to an email, or post on your organization's website
- Print certificates for member reference
- Members may view and print a copy of the certificate, giving them direct access to benefit information
- See the most current documents for your plan, including updates

eServices Demo

For a trial run of our eServices prior to signing up, visit our website, www.standard.com/eservices.

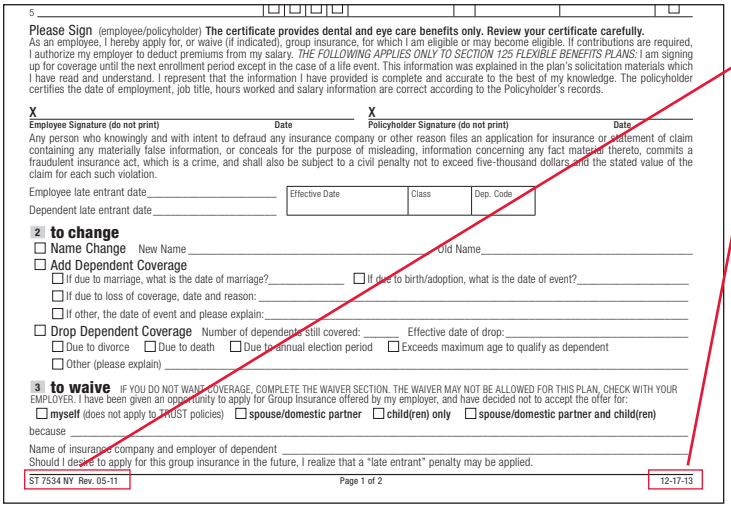
Request eServices

eServices is not available for all groups. Please contact our customer service department at 888-396-8641 for eligibility requirements.

To sign-up for eServices:

1. Visit our website, www.standard.com/eservices and select the "Sign up for eservices" button to access the eAgreement which must be completed to access your policy online.
2. Complete the online form and select "Submit this agreement".
3. After your completed eServices agreement is received, we will assign and send an Authorization ID and PIN number to you.
4. Instructions will be emailed to you for your initial log-in. If you need additional assistance, call our customer service department at 888-396-8641.

Enrollment/Change/Waiver Form Information



Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ Employee Signature (do not print) _____ Date
X _____ Policyholder Signature (do not print) _____ Date

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Employee late entrant date_____ Effective Date | Class | Dep. Code
Dependent late entrant date_____

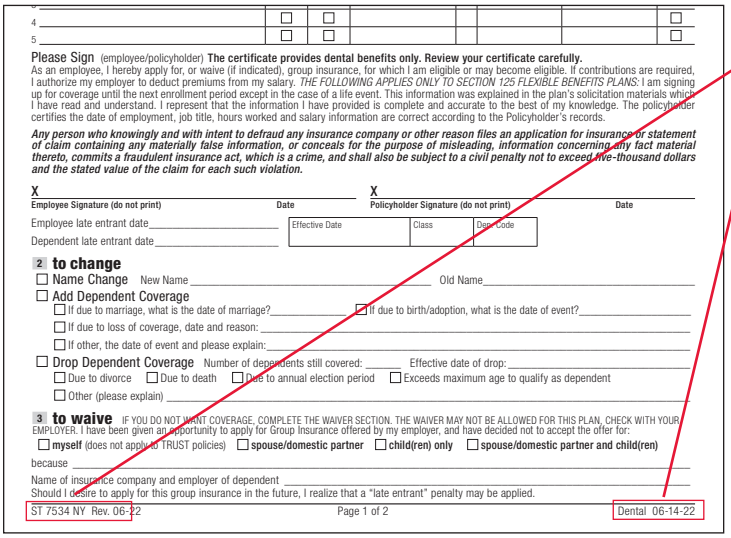
2 to change
☐ Name Change New Name _____ Old Name_____
☐ Add Dependent Coverage
☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____
☐ If due to loss of coverage, date and reason: _____
☐ If other, the date of event and please explain:_____
☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____
☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent
☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:
☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**
because _____
Name of insurance company and employer of dependent _____
Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

ST 7534 NY Rev. 05-11 Page 1 of 2 12-17-13

Dental and Vision Coverage

If you have dental and vision coverage with The Standard, use form **ST 7534 NY 12-17-13**.



Please Sign (employee/policyholder) **The certificate provides dental benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

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X _____ Employee Signature (do not print) _____ Date
X _____ Policyholder Signature (do not print) _____ Date

Employee late entrant date_____ Effective Date | Class | Dep. Code
Dependent late entrant date_____

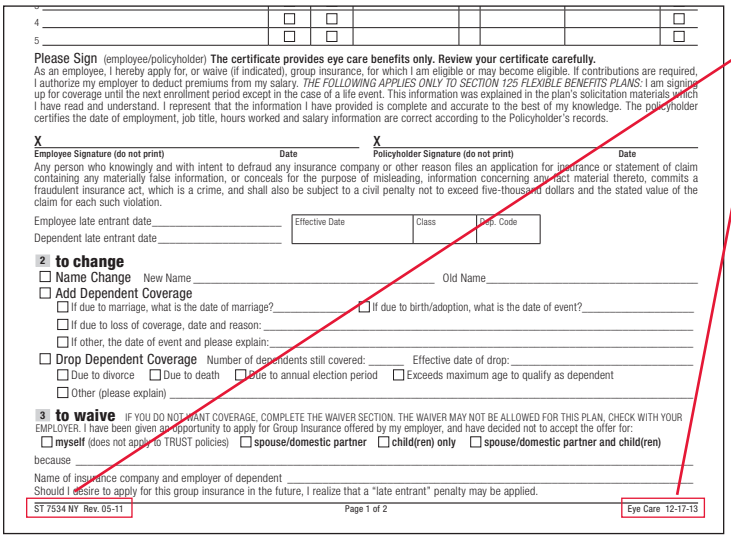
2 to change
☐ Name Change New Name _____ Old Name_____
☐ Add Dependent Coverage
☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____
☐ If due to loss of coverage, date and reason: _____
☐ If other, the date of event and please explain:_____
☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____
☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent
☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:
☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**
because _____
Name of insurance company and employer of dependent _____
Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

ST 7534 NY Rev. 06-22 Page 1 of 2 Dental 06-14-22

Dental Only Coverage

If you have dental coverage with The Standard, use form **ST 7534 NY Dental 06-14-22**.



Please Sign (employee/policyholder) **The certificate provides eye care benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ Employee Signature (do not print) _____ Date
X _____ Policyholder Signature (do not print) _____ Date

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Employee late entrant date_____ Effective Date | Class | Dep. Code
Dependent late entrant date_____

2 to change
☐ Name Change New Name _____ Old Name_____
☐ Add Dependent Coverage
☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____
☐ If due to loss of coverage, date and reason: _____
☐ If other, the date of event and please explain:_____
☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____
☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent
☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:
☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**
because _____
Name of insurance company and employer of dependent _____
Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

ST 7534 NY Rev. 05-11 Page 1 of 2 Eye Care 12-17-13

Vision Only Coverage

If you have vision coverage with The Standard, use form **ST 7534 NY Eye Care 12-17-13**.

notes

enrollment / change / waiver Group Insurance Form

Reset

The Standard Life Insurance Company of New York P.O. Box 82622, Lincoln, NE 68501 / 877-490-9991 / Fax: 402-467-7338

TheStandard®

Policy and Div. # **161-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Are you covered under another **eye care** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental		Eye Care		Relationship	Sex	Date of birth	Social Security no.	College student?
	add	drop	add	drop					
1	☐	☐	☐	☐					☐
2	☐	☐	☐	☐					☐
3	☐	☐	☐	☐					☐
4	☐	☐	☐	☐					☐
5	☐	☐	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

enrollment / change / waiver Group Insurance Form

The Standard Life Insurance Company of New York P.O. Box 82622, Lincoln, NE 68501 / 877-490-9991 / Fax: 402-467-7338

TheStandard®

Policy and Div. # **161-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female ☐ Nonbinary Full time date of hire_____ ☐ Rehire: Rehire date_____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides dental benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

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X _____ _____
Employee Signature (do not print) **Date**

X _____ _____
Policyholder Signature (do not print) **Date**

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

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To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

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TheStandard®

Policy and Div. # **161-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **eye care** insurance plan? . . . . . .**Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1	☐	☐					☐
2	☐	☐					☐
3	☐	☐					☐
4	☐	☐					☐
5	☐	☐					☐

Please Sign (employee/policyholder) **The certificate provides eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

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Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop:_____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive

IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ **myself** (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

tips for filling out this form

To Enroll

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- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

The Standard Life Insurance Company of New York
P.O. Box 82622 / Lincoln, NE 68501-2622
Phone 877-490-9991 Option 1 / Fax 402-467-7338

Electronic Funds Transfer (EFT) Form

Request and Authorization for Bank Payment Plan

It's the simplest method of paying your premium. No more checks to write! It's automatic and reliable. We call it electronic funds transfer (EFT for short). It allows for peace of mind however you do business — whether it's online or through the mail.

Online: Groups that receive invoices online, you have the freedom to choose when we debit your account. When you're ready, just visit our website, standard.com/eservices, sign into your secure account and click PAY BILL. We'll draft your premium payment right away.

Mail: Groups that receive their invoices through the mail, just authorize us to debit your account each month and we'll do the rest. It's the forget-proof method of paying your premium.

Authorized Agreement for Prearranged Payments (Debits)

Group Policy #:_____ Phone #:_____

Policyholder Name: _____

Policyholder Contact: _____

☐ New Authorization ☐ Change of Account
☐ Checking Account ☐ Savings Account

I hereby authorize The Standard Life Insurance Company of New York to initiate debit entries to the account number listed below, and at the bank named below, herein called BANK, to debit the same to such account. The EFT draft will be monthly, on or about the first day of the coverage period.

Bank Account Number:_____ Bank Routing Number *(9 digits)*:_____

Bank Name: _____

Account Name: _____

Address: _____

City: _____ State:_____ ZIP:_____

Phone Number of Financial Institution:_____

To ensure a timely and effective setup, it is necessary to send a voided check with this request.

This authorization is to remain in full force and in effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. A customer has the right to have the amount of an erroneous debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name *(print)*: _____ Title of Authorized Signer:_____

Signature: _____

Date:_____ Federal Tax ID #:_____

Please keep a copy of this form for your records.

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The Standard Life Insurance Company of New York
P.O. Box 82622 / Lincoln, NE 68501-2622
Phone 888-396-8641 / Fax 402-467-7338
The Standard Life Insurance Company of New York – A subsidiary of StanCorp Financial Group, Inc.

Request and Authorized Agreement For Prearranged Payments Via Automated Clearing House (ACH)

- Complete and fax the following form to the number below to initiate ACH payments.
- Remember to mail or fax in documentation on how you arrived at your payment amount each month IF different than the total amount billed.

Policyholder Name:_____ Policy Number:_____

Contact Person:_____ Phone Number:_____

The Standard Life Insurance Company of New York, hereby authorizes the above mentioned policyholder to deposit funds into the account (number listed below), and at the bank named below.

ABA/Routing Number: **121000248**

Account Number: **4121-618-458**

Bank Name: **Wells Fargo**

Bank Address: City: **Omaha** State: **Nebraska**

This authorization is to remain in full force and effect until BANK has received written notification of its termination in such time and such manner as to afford BANK a reasonable opportunity to act on it. The Standard Life Insurance Company of New York has the right to have the amount of erroneous deposited funds credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after the charge, whichever comes first.

Name *(print)*: _____

Signature: _____

Title: _____ Date:_____

Please keep a copy of this form for your records.

Print

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notes

notes

The Standard Life Insurance Company of New York
P.O. Box 5031
White Plains, NY 10602
www.standard.com

ST 1000 NY 10-22

SNY **23191**

(10/22)