

Term Life Coverage Continuation Request



ReliaStar Life Insurance Company
A member of the ING family of companies
PO Box 20, Minneapolis, Minnesota 55440

Instructions

Employer: Read the certificate carefully to determine which coverage(s) are eligible for continuation. Complete and sign the employer section of this form. Send this form along with copies of original enrollment documentation to the employee to complete.

Employee: Complete the employee section below and return the form to the address shown. Be sure to include copies of enrollment documentation 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 Information

Employer or group name State of North Carolina	Policy number(s) 62928-6	Account number	Date payroll deduction terminated	Annual Salary at Termination
Insured name	Social Security No.	Date of birth	Date of hire	Is direct billing the result of a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Voluntary Life effective	Date Voluntary Life premium paid to		Reason for Continuation <input type="checkbox"/> Unpaid LOA <input type="checkbox"/> Employment Terminated	

Coverage type	Coverage Amount at termination	(1) Coverage Amount eligible for continuation	(2) Monthly premium rate per \$1000	Quarterly premium due (coverage x rate x 3)
Employee Voluntary Life				
Total				

(1) Coverage at termination limited by the maximum coverage that can be continued.

(2) For voluntary coverage, premium rates for continuing coverage will typically stay the same as for active employees; however are subject to future increases.

Quarterly Premium Due

Quarterly premium due (total of insured employee premium above)	\$ _____
Quarterly billing charge	+ \$ 3.50
Total payment required with this form	\$ _____

Signature of employer representative	Date	Company telephone number
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This section to be completed by employee

Billing address (street, 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.

Date	Signature of insured employee
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Mail to: NCFlex PO Box 492517 Redding, CA 96049 QUESTIONS? Call NCFlex at: 877-464-5111. FAX: 530-223-7712.

This section to be completed by ReliaStar Life

Date received	Renewal date	Group number	Certificate number	Date mailed
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