Options to keep your group insurance

Portability – Children's Mercy Kansas City

Coverage available *Available without proof of good health.*	Group Hospital Indemnity
Eligibility timing	**Must be elected within 31 days after of receipt of notification of portability.** If coverage is ported, insured will be billed.
Eligible events	**Employee** ▪ Termination of employment ▪ Retirement ▪ Layoff or leave ▪ No longer in eligible class ▪ Termination of group policy without a successor plan ▪ Reduced work hours
Spouse and children eligible events	**Employee** ▪ Terminates employment ▪ Retirement ▪ Layoff or leave ▪ No longer in eligible class ▪ Reduced work hours ▪ Death **Spouse and children** ▪ No longer an eligible dependent ▪ Legal separation or divorce
Not allowed for these events	▪ Termination of group policy with a successor plan ▪ Not actively at work due to sickness or injury ▪ Nonpayment of premium ▪ Do not reside in the United States or its Territory
Amounts allowed to elect *All or a portion of coverage previously in force.*	Employee: Previous benefit plan election or lower Spouse: Previous benefit plan election or lower Child: Previous benefit plan election or lower
Coverage reductions *Reductions apply to minimum and maximum amounts elected.*	Employee: No Reductions Spouse: No Reductions Child: No Reductions
Termination of coverage *The earlier of these events.*	▪ Employee or Spouse attains age 120 ▪ Termination of group policy ▪ Nonpayment of premium ▪ Date the employee again meets the eligibility requirements of the certificate **Spouse and children** ▪ Date your coverage is no longer being continued or ▪ Date they cease to be eligible as defined in your certificate unless they continue coverage on their own

Product name, product features and availability may vary by state. This is a summary of plan provisions related to the insurance policy issued by the company. In the event of a conflict between this summary and the policy and/or certificate, the policy and/or certificate sh652all dictate the insurance provisions, exclusions, all limitations and terms of coverage.

Premium Rates to keep group insurance

Children's Mercy Kansas City

Policy Number 76383

Group Hospital Indemnity Portability

Existing Coverage	Monthly Premium
Employee Only	$20.42
Employee & Spouse	$38.00
Employee & Child(ren)	$27.31
Employee & Family	$46.50
Spouse Only	$17.58
Child(ren) Only	$6.89

All rates are subject to change.

Details on how to keep group insurance

How to choose coverage for yourself and your dependents

- Complete the Election form and sign it. Please note we are unable to accept electronic signatures.
- Make a copy to keep for your records.
- Submit the form to us within **31 days** after loss of eligibility through one of the following options:

Form return options

Attach and submit on: www.lifebenefits.com/filetransfer

Or Fax to: 651-665-4827

Or Mail to: Securian Financial Group, Inc.
PO Box 64086
St Paul, MN 55164-0086

If you have any questions, please call 855-750-1906.

Election - Hospital Indemnity Portability

Securian Life Insurance Company
Minnesota Life Insurance Company
Group Customer Service • 400 Robert Street North, St. Paul, MN 55101-2098

Employer name	Policy number
Children's Mercy Kansas City	**76383**

EMPLOYEE INFORMATION

Name	Date of birth	Sex
		☐ Male ☐ Female

Address (street, city, state, zip)

Email address	Cell or daytime phone number
Date leaving employer's active plan	Employment location

Reason for leaving the employer's active plan (retirement, termination, etc.)

Were you actively at work on the day before your retirement or termination?	If you answered no, was your absence due to sickness or injury?
☐ Yes ☐ No	☐ Yes ☐ No

I choose to keep the following insurance coverage(s) active. Note: If you elect a coverage amount greater than the amount verified by your employer, we will use the verified amount.

Group hospital indemnity coverage I want to keep (select one)

☐ Employee only ☐ Employee & spouse ☐ Employee & child ☐ Employee & family ☐ Spouse only ☐ Child only

DEPENDENT INFORMATION

Name of spouse	Spouse date of birth	Sex
		☐ Male ☐ Female

Name of child	Date of birth	Name of child	Date of birth
Name of child	Date of birth	Name of child	Date of birth
Name of child	Date of birth	Name of child	Date of birth

BILLING INFORMATION

Please indicate how you would like to be billed: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Do not send a premium payment in with this completed form. We will bill you for the premium payment after receiving your completed election form. You will have the option of a monthly EFT draft after your initial payment is received and processed.

A $2 fee is charged *per premium payment* for administrative fees, unless billed annually.

To be eligible for coverage, you must apply within 31 days of the date your previous coverage terminated.

Employee/Applicant signature	Date signed
X	