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Standard Insurance Company

CTA Benefits and Services
PO Box 4744 Portland OR 97208
Tel & TTY 800.522.0406 Fax 888.414.0393

Coverage Termination for CTA-Endorsed Plans

For additional information and forms go to Member Benefits at: www.cta.org

Use this form if you would like to terminate part or all of your Insurance coverage. Mark all applicable boxes and complete all applicable sections. Please return the completed form to The Standard.

Employee Information ** Required fields.*

SIC USE ONLY	POLICY NO.	PARTICIPANT ID		
FIRST NAME*		MIDDLE INITIAL	LAST NAME*	PHONE NUMBER*
MAILING ADDRESS*			CITY*	STATE* ZIP*
SCHOOL DISTRICT* *Please do not abbreviate.*				

Coverage(s) to be Terminated *Required*

- ☐ **ALL COVERAGES**
- ☐ Disability Insurance
- ☐ Life Insurance with Accidental Death & Dismemberment (AD&D)
- ☐ Dependents Life Insurance (Spouse/Domestic Partner) with AD&D
- ☐ Dependents Life Insurance (Spouse/Domestic Partner and Children) with AD&D

Reasons for Termination *Required*

- ☐ **Declining Coverage** (indicate reason below)
  - ☐ Going to another carrier (specify carrier) _____
  - ☐ No longer need coverage
  - ☐ Becoming an Administrator
  - ☐ Cost of premiums
  - ☐ Not satisfied with The Standard's service (specify) _____
  - ☐ Other (specify) _____

You may be able to continue your insurance for the following (you will be sent applicable continuation information along with a letter confirming your coverage termination). If you do not wish to continue your insurance and are on a Leave of Absence, you must inform The Standard within 120 days of returning to work to reinstate your coverage without proof of good health.

- ☐ **Retirement** Last Date of Work _____
- ☐ **Leave of Absence** (not related to a **claim**) Last Date of Work _____
- ☐ **Layoff** Last Date of Work _____
- ☐ **Transferring to a public research position** Last Date of Work _____

Signature Required

I wish to make the choices indicated on this form. I agree that my coverage is subject to the terms and conditions of the Group Policy. I understand that if my insurance cannot be continued, any premium advanced by me will be refunded. I understand that my premium amount will change if my coverage or costs change. This authorization will remain in effect until cancelled by me or by The Standard.

Participant Signature _____ Date _____

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