# Request for Continued Life Insurance/ Long Term Disability Direct Payment Authorization

Standard Insurance Company, Continued Benefits – PSB8A
920 SW Sixth Avenue   Portland OR 97204

Note: No CSU contribution will be made toward the premium payable during absence.

## Part A – Employee Information

| Name: (first) (middle) (last) | | | | Soc. Sec. No.: |
|---|---|---|---|---|
| Mailing Address: | City: | State: | Zip: | Home Phone: ( ) |
| Date of Birth: | Monthly gross earnings: | | | |
| Spouse Name: | Spouse DOB: | Child Name: | | Child DOB: |

## Part B – Employee to Sign if he/she DOES NOT Desire to Continue Coverage

I do not desire to continue my Life/LTD insurance coverage while off pay status. I understand that my life insurance coverage will lapse while off active pay status, effective on the date of my leave of absence.

Employee Signature: ______________________ Date: ____________

## Part C – Employee to Sign if he/she DESIRES to Continue Coverage

I request continuance of my Life/LTD insurance coverage during the time I will be temporarily off pay status. I agree to make direct payment of the total premium to the insurance carrier. I understand that failure to make timely premium payments while off pay status, and/or failure to notify the carrier of loss of eligibility due to a permanent separation or retirement, will result in termination of my coverage and the carrier's liability. I understand that I will not be billed by the carrier and that I must pay the premium for the month in which I return to active pay status.

I agree to pay to:
Standard Insurance Co.
Attn: Continued Benefits – PSB8A
920 SW Sixth Avenue
Portland, OR 97204

the total premium of $ ________ if my leave is 6 months or less. If my leave is longer than 6 months, I will either pay the total amount of $ ________ or make quarterly payments of $ ________. Quarterly checks are due to the carrier prior to the tenth of the month preceding the first month of each quarter. Refunds will be made for full months of overpayment only (partial months cannot be refunded).

Employee Signature: ______________________ Date: ____________

## Part D – (To be Completed by Benefits Officer)

Type of Absence: ______________________

Dates of Absence: From: ____________ To: ____________

Employee to pay for the months of ____________ through ____________

Employee Occupation: ______________________

Employing Campus: ______________________ Agency Code: ____________

Address: ______________________

Phone: (____) ____________

Definition of class by contract: ____________

I certify that all of the above information is correct according to our records.

Campus Signature: ______________________ Date: ____________

Distribution: If employee chooses not to continue: provide one copy to employee and file original.
If employee chooses to direct pay: provide one copy to employee, place original in file, and send one copy to carrier.

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