reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Hospital Indemnity Portability/Continuation Request

Reset

This form is to be used only when a person desires and is eligible to continue Hospital Indemnity Insurance. This form must be completed in full and submitted to The Company within 31 days following the date of termination of insurance coverage.
SEND TO: Amwins Group Benefits, Inc., P.O. Box 152501, Irving, TX 75015-2501 - irvcustomerservice@amwins.com - Fax#: 469-417-1675

VERIFICATION OF INSURED PERSON'S ELIGIBILITY TO CONTINUE HOSPITAL INDEMNITY

To Be Completed By Policyholder/Participating Unit

☐ Male ☐ Female

1. Insured Person's full name_____ 2. Soc. Sec. Number_____
(Please Print)

3. Name of Policyholder/Participating Unit _____4. Policyholder/Participating Unit No.: VHI_____

5. Branch or Location (if different from 3.) _____

6. Date of Hire:_____ Class: _____

7. Effective Date of Coverage: Employee:_____ Spouse, if any:_____ Children, if any:_____

8. Date Person Last Worked _____

9. Date Coverage Terminated (if different from 8.) _____

10. If (8) and (9) differ, please explain _____

11. Plan and Coverage in force, applicable to this Insured, under the Policy on date of termination of insurance coverage:
Plan: ☐ Voluntary Hospital Indemnity

Coverage: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

12. Verified by _____
(Signed by authorized individual) Date Phone Number

To Be Completed By Applicant

Name _____ Spouse's Name _____

Date of Birth: Employee_____ Date of Birth: Spouse_____ Date of Birth Children, if any _____

Address _____
(Street) (City) (State) (Zip)

Coverage Desired: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren)
☐ Employee, Spouse & Child(ren)

Plan and Coverage elected to be continued **may not exceed Plan and Coverage option in force,** applicable to this Insured, under the Policy on date of termination of insurance coverage

Beneficiary:

Full Name(s)	Relationship	Percent of Proceeds	SSN
_____	_____	_____	_____
_____	_____	_____	_____

Signature of Applicant	Email Address	Phone Number	Date Signed
_____	_____	_____	_____