KPERS

KPERS-79C Rev. 1/17

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OPTIONAL GROUP LIFE INSURANCE CONTINUATION

Instructions on page 2.

■ **General Information –** This form must be submitted to the Retirement System within 60 days of the last day you are on your employer's payroll.

This form is for employees under age 65 who:

- Are already enrolled in optional group life insurance.
- Qualify for one of the continuation criteria in Part B, #1.
- Want to continue member, spouse or child coverage while off their employer's payroll.

If you are over age 65, you may convert your group life insurance to an individual policy by completing a Life Insurance Conversion Form. A portability option is available if you are under age 80. Download all forms at kspers.gov or see your designated agent.

■ **Contact Us – toll free**: 1-888-275-5737 • **phone**: 785-296-6166 • **fax**: 785-296-6638
email: kpers@kspers.gov • **web:** kspers.gov • **mail**: 611 S. Kansas Ave., Suite 100, Topeka, KS 66603

■ Part A – Employee Information

1. Social Security Number: _____
2. Name (First, MI, Last): _____
3. Date of Birth: _____
4. ❒ Male ❒ Female
5. Telephone Number: _____
6. Mailing Address: _____
   City, State, Zip: _____

■ Part B – Coverage To Continue – You can decrease from your current amount, but you cannot increase.

1. Reason for leaving payroll (choose only one): See instructions for continuation criteria.
   ❒ Employee Illness ❒ FMLA for Family Illness ❒ Non-FMLA Event ❒ Military Leave
2. Complete table below for coverage you wish to continue.

OGLI Coverage Type	*Current Coverage*	*Amount To Continue*	*Continuing Coverage Details*
Employee	$	$	*If decreasing coverage, must be in $5,000 increments.*
Spouse	$	$	*If decreasing coverage, must be in $5,000 increments.*
Child	$	$	*Must choose either $10,000 or $20,000.*

3. If continuing spouse coverage, provide your spouse's information below.
   Social Security Number: _____ Name (First, MI, Last): _____
   Date of Birth: _____ ❒ Male ❒ Female
4. Please indicate which payment method you prefer: ❒ Annually ❒ Semi-Annually ❒ Quarterly
   A $1.00 administrative fee applies for semi-annual and quarterly premium payments.
5. Enter billing address if different than mailing address.
   Billing Address: _____ City, State, Zip: _____
6. Employee Signature: _____ Month/Day/Year: _____/_____/_____

■ Part C – Employer Certification – This section must be completed and signed by the employer's designated agent.

1. Employer: _____
2. Employer Number: _____
3. Last Date on Payroll: _____
4. Date of Disability: _____
5. Designated Agent Signature: _____ Month/Day/Year: _____/_____/_____

OPTIONAL GROUP LIFE INSURANCE CONTINUATION INSTRUCTIONS

■ Part A – Employee Information

1-6. Enter indicated personal information.

■ Part B – Coverage To Continue – You can decrease from your current amount, but you cannot increase.

1. Mark the corresponding box to indicate the reason for leaving your employer's payroll. Please choose only one. You must meet one of the continuation criteria to continue optional group life insurance.

   Employee Illness: You have an illness or injury, and have a disability claim pending. You can continue coverage until the earliest of: recovery, retirement, reach age 65, or withdraw contributions.

   FMLA for Family Illness: Family member must be a spouse, parent, child under age 18, or a child over 18 with a disability that prevents them from caring for themselves. You can continue coverage for up to 12 months.

   Non-FMLA Event: Includes sabbatical, funeral leave, short-term minor illness not requiring hospitalization, and other non-medical reasons. You can continue coverage for up to 12 months.

   Military Leave: Can continue coverage for up to 16 months during military leave.

2. Complete the blanks in the table for employee, spouse and child coverage you wish to continue while you are off your employer's payroll. You can decrease coverage from your current amount, but you cannot increase.

   Employee Coverage: You can stay the same or decrease coverage in $5,000 increments.

   Spouse Coverage: You can stay the same or decrease coverage in $5,000 increments.

   Child Coverage: You can decrease from your current coverage, but you cannot increase your coverage. You must choose either $10,000 or $20,000.

3. If continuing spouse coverage, please provide your spouse's indicated personal information.

4. Standard Insurance Company will bill you for your first premium payment after processing your request to continue coverage. You can pay for future premiums quarterly, semi-annually or annually. A $1.00 administrative fee is charged for each semi-annual or quarterly premium payment. Indicate which payment method you prefer.

5. Enter the address you want used for billing purposes, if different from your mailing address in Part A.

6. Sign and date the form.

■ Part C – Employer Certification – This section must be completed and signed by the employer's designated agent.

1-2. Enter the employer name and number.

3. Enter the last date the employee was on your employer's payroll.

4. Enter the date of the employee's disability, according to his or her KPERS-60 form.

5. Sign and date the form. The Retirement System will only accept the designated agent's signature on file or an authorized representative whose signature is also on file.