INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT (herein called IAC)
930 E. 2nd Street, Suite 100 Edmond, OK 73034 ♦ 1-800-821-5434

Group Life Insurance – Marshall Islands – Waiver of Premium Election Form

First Name	Middle Name	Last Name
Date of Birth	Social Security Number	Government Department

		Acknowledgement (Initial Each Box)
1.	I am terminating my employment with this government agency/department. I understand that if I am less than age 60 and can no longer work due to a **Permanent Total Disability**, I may qualify for Disability Waiver of Premium and that my premium may be waived according to the terms of the Group Master Policy.	
2.	I understand that I must be unable to perform the duties of any occupation and there is a 9 month waiting period during which time my disability will be evaluated and approved or denied.	
3.	To continue coverage during the 9 month waiting period, I further understand that the full premium (both employee and employer portion) must be paid in a lump sum premium for the entire 9 month waiting period within 61 days of the earlier of my last day actively at work or the paid through date of the last premium payment. If the full lump sum premium is not received by IAC on a timely basis, my coverage will terminate as of the last timely premium paid through date.	
4.	I further understand that I must provide satisfactory proof of my Permanent Total Disability initially and annually thereafter and I am not guaranteed that my claim will be approved simply because I completed this election form and paid the required lump sum premium.	
5.	Please choose ONE of the following options: ☐ My employment has terminated because I am Permanently and Totally Disabled and I wish to apply for the Basic Life Insurance Waiver of Premium Benefit. I understand that the lump sum premium for the 9 month waiting period is due now. If the lump sum premium is not received by IAC on a timely basis, my coverage will terminate as of the last timely premium paid through date. I further understand that Dependent's Term Life Insurance coverage does not continue and that I can apply for conversion benefits for the dependent coverage. Lump Sum Premium Calculation Employee Basic Life biweekly premium: $_________ (***a***) Employer Basic Life biweekly premium: $_________ (***b***) Total Basic Life biweekly premium (lines ***a*** plus ***b***): $_________ (***c***) Lump sum premium due for 9 months (multiply line ***c*** times **20**): $_________ Total Premium due ☐ I do not want to apply for the Waiver of Premium Benefit. I understand that my coverage terminates as of the paid through date of the last timely premium payment. By checking this box, I understand that this is my written notice from IAC that my insurance is terminated.	
6.	I understand that if the Group Master Policy with IAC is terminated that Waiver of Premium Benefits will also terminate.	

By signing this form, I hereby attest that I have read and understand the above information and declare that the above statements and answers are complete and true to the best of my knowledge and belief.

Signature:____ Date:__________________________

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud which is a crime and subjects such person to criminal and civil penalties.

TO BE COMPLETED BY EMPLOYER			
Group:	Annual Salary: $	Basic Life Coverage: $	Terminate Date:
TO BE COMPLETED BY HOME OFFICE			
Date Form Received:	Premium Received: $	Date:	Follow Up Date: