Group Term Life Insurance
Election of Portability Coverage

Planholder Name (Company Name)			Group Plan No.	
Employee's Name (Last, First, MI)	Soc. Sec. No.		Birth Date	Sex ☐ M ☐ F
Employee's Home Address (Street, City, State, Zip)				
Home Telephone Number	Work Telephone Number	Date Employment Terminated		
Reason Employment Terminated				
Have You Applied or Will You Apply for the Extended Life Benefit under Your Employer's Plan?				

Please complete the following information for all dependents to be covered:

Name (Last, First, MI)	Social Security Number	Sex	Birth Date	F/T Student
Spouse		☐ M ☐ F		
Child(ren)		☐ M ☐ F		☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No
		☐ M ☐ F		☐ Yes ☐ No

The following individuals are eligible to port the Life Insurance: the employee; the employee and his/her spouse; or the employee and all eligible dependents. Also, in the event of the employee's death, a surviving spouse under age 70 may port the coverage for him/herself and all eligible dependent children.

Please indicate whose coverage will be ported:

☐ Employee Only
☐ Employee and Spouse
☐ Employee and All Eligible Dependents
☐ Surviving Spouse
☐ Surviving Spouse and Child(ren)

The amount that is eligible to be ported is a dollar amount equal to:

Option A - The full amount of the inforce group term insurance; or
Option B - 50% of that amount (provided the ported amount is not less than $25,000 on the employee, $2,500 on the spouse and $1,000 on the child(ren).

Please indicate whether you elect Option A or Option B.

☐ Option A ☐ Option B

Please indicate your beneficiary designation:

Name of Beneficiary: ______________________________ Relationship ____________________

The enclosed Premium Notice outlines the monthly premium rates for this coverage and the modes of payment.

Within 31 days of the date your employment terminates, you must submit: (a) this completed form: (b) your premium payment; and (c) proof of insurability, if required by this group plan. If proof is required, your ported coverage is effective when we approve the proof in writing. For your insurance to remain in force and prevent cancellation of coverage, we must receive all subsequent premium payments within 31 days of the applicable premium due date. If we do not receive your premium, your coverage will automatically terminate at the end of 31 days and you will owe us all unpaid premiums for the period this coverage was inforce.

Coverage is reduced by 35% at age 65. Coverage terminates at age 70.

Signature: ______________________________ Date: ____________________