Application for Portability of Voluntary Term Life Insurance
(Employee, Spouse or Domestic Partner and Child/ren)

Underwritten by Life Insurance Company of North America, a Cigna Company
(Herein called the Insurance Company)

EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER.

Please print (preferably in black ink).

Employer/Policyholder Name: _____ Group Policy Number: _____

Name of Employee: _____ Class Number: _____

Date of Hire: _____ (Month/Day/Year) Coverage End Date: _____ (Month/Day/Year) Employment Termination Date: _____ (Month/Day/Year)

Last Day Worked: _____ (Month/Day/Year) Salary as of the last day worked: $ _____ Effective Date of Salary: _____ (Month/Day/Year)

Reason for loss of Group Insurance: *(not all reasons may qualify for portability)* Check All that apply.

☐ Termination of Employment ☐ Change to Another Class ☐ Retirement
☐ End of Continuation Provision ☐ Temporary Layoff ☐ Paid Leave of Absence ☐ Unpaid Leave of Absence
☐ FMLA ☐ Sabbatical ☐ Disability (STD) ☐ Disability (LTD) ☐ Other: _____

Reminders:

1) **If coverage terminates due to group policy cancellation, portability is not an option.**
2) **If an Accelerated Death Benefit (ADB) (example: Terminal Illness) was paid under the group policy for any insured, please enter the full amount of group coverage without the ADB reduction for that applicant.**
3) **If coverage has already been reduced because of age, report both the original amount and the reduced amount as instructed below.**

Voluntary Life Coverage Amount Eligible for Portability:

Premium paid through date for Voluntary Life Coverage: _____ (Month/Day/Year)

Employee Coverage Amount $ _____ **Group Coverage Effective Date:** _____ (Month/Day/Year)

Has an Accelerated Death Benefit (ADB) been paid on the Employee? ☐ Yes ☐ No *(If Yes, see Reminder #2 above)*

Has the Employee coverage been reduced because of age? ☐ Yes ☐ No *If Yes, complete the next line.*

Coverage amount (before any age reductions) $ _____ Coverage amount (after last age reduction) $ _____

Spouse or Domestic Partner Coverage Amount $ _____ **Group Coverage Effective Date:** _____ (Month/Day/Year)

Has an Accelerated Death Benefit (ADB) been paid on the Spouse or Domestic Partner? ☐ Yes ☐ No *(If Yes, see Reminder #2 above)*

Has Spouse or Domestic Partner coverage already been reduced because of age? ☐ Yes ☐ No *If Yes, complete the next line.*

Coverage amount (before any age reductions) $ _____ Coverage amount (after last age reduction) $ _____

Child Coverage Amount $ _____ **Group Coverage Effective Date:** _____ (Month/Day/Year)

Verification provided by:

_____ _____ **Date of Notice:** _____
Employer/Policyholder Signature *Title* (Month/Day/Year)

Telephone Number: _____ E-Mail Address: _____

Notes to Employer/Policyholder: *Be sure to check the group policy for* ***portability limitations*** *(i.e. age and/or dependent limitations).*

If ***ownership of coverage*** *has been assigned, the Owner may be other than the employee and you will need to provide notice to the assignee, not to the employee.*

If any ***voluntary life coverage*** *was elected, please include enrollment history (forms and screen prints) for the coverage elected.*

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Employee Name: _____ Social Security Number: _____

**** THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE.
HOWEVER, IF THE OWNERSHIP OF THE LIFE INSURANCE HAS BEEN ASSIGNED TO A THIRD PARTY,
THE ASSIGNEE MUST COMPLETE THIS FORM. ****

IMPORTANT:

- **If you or any of your dependents had to submit medical evidence of good health for any part of the life insurance amount, please provide a copy of the approval letter, and/or any other related documentation that you received regarding the decision rendered.**

SECTION A

Please print (preferably in black ink).

EMPLOYEE INFORMATION

Employer's Name: _____ Group Policy Number: _____

Employee's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Birth date: _____ (*Month/Day/Year*) Social Security Number: _____

Day Phone: _____ Evening Phone: _____

1. Last Day Worked: _____ (*Month/Day/Year*) **Were you disabled on your coverage end date?** ☐ **Yes** ☐ **No**

2. Reason for leaving work: _____

3. If you wish to continue your coverage, please check the appropriate box :

Voluntary Coverage

☐ Continue amount of coverage currently in force

☐ Decrease the coverage amount to $ _____ (*Units of $1,000*)

☐ *Increase your coverage to $ _____ (*Units of $1,000*)

**See "Coverage Increases" under the General Information section of this form.*

4. Have you applied for: (Check all that apply)

☐ Conversion to an individual policy Application Date: _____ (*Month/Day/Year*)

☐ Waiver of Premium Application Date: _____ (*Month/Day/Year*)

☐ Accelerated Death Benefit (ADB) Application Date: _____ (*Month/Day/Year*)

***Note**: The portability death benefit amount will be reduced by the amount of coverage paid under the ADB Claim (Example Terminal Illness), however, the portability premiums may be required to be paid on the full amount of coverage in place prior to the reduction.*

Employee Name: _____ Social Security Number: _____

SPOUSE OR DOMESTIC PARTNER INFORMATION

Note: If the Employee is applying to continue coverage for a Spouse or Domestic Partner as defined under the term life policy, the Employee must answer questions 1 and 2 below.

Spouse's or Domestic Partner's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Birth date: _____ (Month/Day/Year) Social Security Number: _____

Day Phone: _____ Evening Phone: _____

1. If you wish to continue coverage for your Spouse or Domestic Partner, please check the appropriate box:

Voluntary Coverage

☐ Continue amount of coverage currently in force

☐ Decrease the coverage amount to $ _____ (Units of $1,000)

☐ *Increase your coverage to $ _____ (Units of $1,000)

**See "Coverage Increases" under the General Information section of this form.*

2. Has your Spouse or Domestic Partner applied for: (Check all that apply)

☐ Conversion to an individual policy Application Date: _____ (Month/Day/Year)

☐ Accelerated Death Benefit (ADB) Application Date: _____ (Month/Day/Year)

***Note**: The portability death benefit amount will be reduced by the amount of coverage paid under the ADB Claim (Example Terminal Illness), however, the portability premiums may be required to be paid on the full amount of coverage in place prior to the reduction.*

CHILD/REN INFORMATION

Note: If the Employee is applying to continue coverage for a Dependent Child or Children, the Employee must complete the information below. Please note, you cannot continue child coverage unless each child meets the age and dependency requirements as defined in the group policy.

Do you wish to continue coverage for your dependent child(ren)? Voluntary Coverage ☐ Yes ☐ No

Dependent Child's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Birth date: _____ (Month/Day/Year) Social Security Number: _____

Phone Number: _____

Dependent Child's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Birth date: _____ (Month/Day/Year) Social Security Number: _____

Phone Number: _____

If you have additional children, attach, sign and date a separate sheet of paper using the format above.

Employee Name: _____ Social Security Number: _____

BENEFICIARY INFORMATION

The Employee or the Assignee (if the Employee has Assigned ownership) must specify a beneficiary by completing the section below. When specifying multiple beneficiaries, the insured must indicate the percentage of distribution for each and the total must equal 100%. Any benefits that remain undesignated will be paid in accordance with the applicable provisions of the policy/certificate. If there is not enough room to specify all beneficiaries (e.g. Primary and Contingent beneficiaries), attach, sign and date a separate sheet of paper using the format below:

Beneficiary Name, Address, Phone Number (Employee Coverage)	Percentage Total: 100%	Social Security Number	Date of Birth (Month/Day/Year)	Relationship
	%			
	%			
Beneficiary Name, Address, Phone Number (Spouse or Domestic Partner Coverage)	**Percentage Total: 100%**	**Social Security Number**	**Date of Birth (Month/Day/Year)**	**Relationship**
	%			
	%			
Beneficiary Name, Address, Phone Number (Children Coverage)	**Percentage Total: 100%**	**Social Security Number**	**Date of Birth (Month/Day/Year)**	**Relationship**
	%			
	%			

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse's Signature: _____ Date: _____ (Month/Day/Year)

SECTION B Complete this section only if the current Owner is other than the Employee.

Owner - The Owner is the person who has the right to assign, surrender, and exercise all other rights contained in the contract. If no other Owner is designated, the Employee shall be the Owner. All correspondence and premium notices will be mailed to the Owner. If you wish to designate someone other than yourself as the owner, an assignment form must be completed.

Owner Name: _____ Tax I.D./Social Security Number: _____

Street Address: _____ Telephone Number: _____

City: _____ State: _____ Zip Code: _____

Please sign and date here

If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).

Owner's Signature: _____ Date: _____

(Must be signed by Owner if other than employee.) (Month/Day/Year)

Read the Agreements and Authorization section that follows. Sign and date the form in the spaces provided.

* * * AGREEMENTS AND AUTHORIZATION * * *

To the best of my knowledge and belief all written, telephonic and electronic information I gave is true and complete.
The conditions for the requested Insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions.

Please sign and date here

If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).

Employee's Signature: _____ Date: _____ (Month/Day/Year)

Caution: *Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.*

Employee Name: _____ Social Security Number: _____

GENERAL INFORMATION

1. **Eligibility -** Age limitations may exist which will limit your eligibility to continue your coverage. These limitations may be reviewed in your originally issued Certificate. If you do not meet the age requirements to continue your coverage, you can convert this coverage to an individual whole life policy then offered by the Insurance Company.

2. **Rates** - Please note that rates under the Portability Option may be higher than those you paid previously, and they are subject to change. If you would like an estimated premium before applying for coverage, please call 1-800-423-1282.

3. **Deadline** - You have 31 days from the coverage end date to exercise the Portability Option. If you were not notified of this right at least 15 days prior to the end of the 31-day period, you will have 15 days from the date notice is given to submit your Portability application to continue coverage. In no event will this period be extended beyond 91 days.

4. **Effective Date** -The effective date of your continued coverage will be the first day of the month following the coverage end date as reflected in the 'Employer Use Section' of this application or in the letter notifying you of your portability and conversion options, if applicable.

5. **Billing** - You will be billed on a quarterly basis. After the initial bill, you will receive your bill approximately 30 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly.

6. **Coverage Increases -** You may be able to increase your coverage in accordance with the terms of the group policy. If coverage increases are allowed under your plan (see your Certificate for details), you must provide satisfactory evidence of good health, and be approved by the Insurance Company. Please indicate in *"Section A"* of the application if you want to increase your coverage for yourself and/or your Spouse or Domestic Partner; a medical questionnaire form will be mailed to you.

7. **Coverage Decreases -** The group policy may limit dependent coverage (for your Spouse or Domestic Partner or your Children) to a percentage of the Employee's coverage amount. If you voluntarily elect to decrease your coverage, dependent coverage may also be required to be reduced at the same time if the policy contains this type of limitation (see your Certificate for details).

8. **Coverage Reductions** - Any age-related reductions in insurance may continue to apply. The Conversion Privilege related to any partial loss of coverage remains subject to the terms of the group policy (see your Certificate for details).

9. **Coverage Terminations** - Coverage will end as provided in the Portability Option of the group policy. Age-related termination of coverage may apply. When your coverage under the group policy ceases (for reasons other than non-payment of premium), you may be able to convert this coverage within the specified timeframe to an individual whole life policy then offered by the Insurance Company (see your Certificate for details).

Mail your completed and signed form to:

AmWINS Group Benefits Inc., P.O. Box 152501, Irving, TX 75015-2501

For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.