



Important Information When Considering Portability Coverage

When your group term life insurance coverage ends, either because your employment has terminated or you no longer are eligible to participate in your employer’s group life policy, you have two choices for continuing your life insurance coverage: Portability or Conversion. While there are a number of differences between portability and conversion, some key considerations are:

- **Portability** allows you and your dependents to continue (or “port”) your Life and/or AD&D coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer’s group life insurance policy. **Importantly, you cannot port coverage for anyone who has an injury or sickness which has a material effect on life expectancy.**
- **Conversion** allows you and your dependents to purchase individual life insurance policies (but not AD&D) at rates that may be higher than portability rates. The conversion policies you choose will not contain the exact same coverage you had under your employer’s group life insurance policy. **Unlike portability, conversion is available even if you or your dependents have a sickness or injury which has a material effect on life expectancy.**

If you believe Portability is right for you, read the information below to determine whether you and your dependents are eligible to port your coverage.

PORTABILITY COVERAGE IS NOT AVAILABLE FOR ANYONE WITH AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. This means individuals diagnosed with, or having received medical advice or sought treatment for, any of the following injuries or sicknesses in the past 10 years cannot elect this coverage:

| | |
|---|--|
| <ul style="list-style-type: none"> • Acquired immune deficiency syndrome (AIDS) • Amyotrophic lateral sclerosis (ALS) • Cerebral palsy with cognitive impairment • Chronic renal disease • Chronic lung disease, including emphysema • Cirrhosis of the liver • Congestive heart failure • Coronary artery disease, heart surgery, or transient ischemic attack (TIA) • Cystic fibrosis • Dementia, including Alzheimer’s disease • Diabetes other than gestational or diet controlled • Drug or alcohol abuse • Hepatitis B or C • High blood pressure concurrently treated with three or more medications | <ul style="list-style-type: none"> • Leukemia, lymphoma or any cancer other than basal or squamous cell carcinoma of the skin • Morbid obesity defined as a Body Mass Index (BMI) greater than 40 <p><i>Calculate a BMI using the Center for Disease Control’s BMI Calculator online at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html or call us with height/weight information and we’ll calculate it for you.</i></p> <ul style="list-style-type: none"> • Muscular dystrophy • Psychiatric hospitalization • Quadriplegia • Stroke • Systemic lupus erythematosus or any other rheumatologic disease |
|---|--|

If you are not sure whether anyone applying for this coverage has an injury or sickness in the list above, then attach to this election form the name of the individual with the injury/sickness, his/her relationship to you, a description of the condition, and any current medications. Unum will review the information provided and let you know whether portable coverage is an option.

Important: When a life insurance claim is submitted to Unum on an individual who died within two years of the date that portability coverage became effective, Unum reviews medical records to determine whether the deceased individual was eligible for portability. If Unum determines the deceased individual wasn’t eligible for portability due to an injury or sickness which had a material effect on life expectancy, the beneficiary will not receive the portability amount elected. Instead, the beneficiary will receive a significantly reduced benefit (or possibly no benefit at all). Please see the Portability section of your employer’s group policy for an explanation of how the benefit may be reduced.

If after reading the information on this page you believe you and/or your dependents aren’t eligible to elect portability coverage, remember that you and your dependents may qualify for conversion coverage. Contact your employer for the conversion application form and rates.

If you believe you and/or your dependents are eligible for portability, continue to page 2.

Important Information

What type of coverage can be ported?

- **Basic Life** is insurance that your employer provided for you when you were in active employment.
- **Supplemental Life** is insurance elected by you for which you paid the premiums when you were in active employment.
- **AD&D** is Accidental Death & Dismemberment coverage and may not exceed Life coverage.

What are your employer's responsibilities?

- Fully complete Section 1 on page 3 of this election form and provide it to the employee. Incomplete election forms may result in a denial of coverage.
- Provide the portability rate table to the employee.

What are your responsibilities as the employee?

- Complete Section 2 on page 3 and the Beneficiary Designation Form on page 4. Incomplete forms may be denied.
- Portable coverage is available in amounts up to your current coverage amounts without evidence of insurability—but cannot exceed \$750,000 across all Unum Life and AD&D coverages.
- If you wish to elect coverage in an amount other than your current coverage amount, provide the requested amounts. Coverage is subject to the minimum and maximum limits provided in the employer's policy. Contact your employer for a copy of the group life insurance policy.
- An initial premium payment must be submitted with this election form within 31 days from the date your coverage ends.
- Please remember to (1) include the initial premium payment; (2) sign and date page 3 of this election form; (3) designate a beneficiary on page 4; and (4) retain a copy of this entire form for your records.
- Mail pages 3 and 4 of this election form and your initial premium payment to the address listed at the top of page 3.

What should you know when completing your Beneficiary Designation Form?

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).
- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).
- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a child's court-appointed financial guardian. The regulations governing minor beneficiaries vary by state.
- **Trust** – You may designate a valid trust as a beneficiary.
- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.
- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.



TERM LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE

Submit to: Unum Life Insurance Company of America (Unum) Portability Unit
2211 Congress Street, Portland, ME 04122 • 1-800-421-0344 • Fax 207-575-2993

EMPLOYER COMPLETES SECTION 1

| | | | | |
|----------------------------------|---|---|----------------------|----------------------|
| Company Name: | | Policy Number | Division | Class |
| | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Employee Name (Last, First, MI): | | Policy Number | Division | Class |
| | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date Coverage Ends (mm/dd/yyyy): | Insured on disability or sick leave when terminated? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If Yes, date premium paid to: _____ | Reason for Loss of Coverage: | | |
| Current Annual Earnings: | | <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Retired <input type="checkbox"/> Reduced Hours (must be working) <input type="checkbox"/> Other, Explain _____ | | |

Fill in Current Coverage Amounts for Each Insured and Insurance Type

| Insured Type | Basic Life | Supplemental Life | Basic AD&D | Supplemental AD&D |
|--------------|------------|-------------------|------------|-------------------|
| Employee | | | | |
| Spouse | | | | |
| Child | | | | |

| | |
|--------------------------------------|-------------------------------|
| Plan Administrator Name: | Plan Administrator Signature: |
| Plan Administrator Telephone Number: | Plan Administrator Email: |

EMPLOYEE COMPLETES SECTION 2

| | | | |
|---|-------------------------------------|--|------------------|
| Insured Mailing Address (Street, PO Box, City, State, Zip): | | Home Telephone: | |
| | | Alternate Telephone: | |
| Insured Social Security Number: | Insured Date of Birth (mm/dd/yyyy): | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Spouse Name: | Spouse Date of Birth (mm/dd/yyyy): | Spouse Social Security Number: | |
| Child Name: | Date of Birth: * | Child Name: | Date of Birth: * |
| Child Name: | Date of Birth: * | Child Name: | Date of Birth: * |

* Check the policy or your certificate. Dependent eligibility is subject to age, student and/or marriage status.

| | |
|--|---|
| Have you used tobacco products in the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No | Has your spouse used tobacco products in the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|

Fill in Requested Coverage Amounts for Each Insured and Insurance Type - coverages left blank will result in a coverage amount of \$0. Coverage reduces according to your employer's group insurance policy.

| Insured Type | Basic Life | Supplemental Life | Basic AD&D | Supplemental AD&D |
|--------------|------------|-------------------|------------|-------------------|
| Employee | | | | |
| Spouse | | | | |
| Child | | | | |

Select a premium payment option:
 Quarterly (Every three months) Semi-Annually (Every six months) Annually (One time per year)
Make your check or money order payable to Unum.

I understand and agree to the following:
Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Unum group term life coverage and/or Accidental Death and Dismemberment insurance coverage under which this coverage is being offered and is subject to satisfaction of the conditions provided therein.

Portable coverage will be effective the first of the month after your group coverage ends subject to your applying for portable coverage for yourself and your dependents and paying the first premium within 31 days after the date your group coverage ends.

HAVING READ AND UNDERSTOOD THE "IMPORTANT INFORMATION WHEN CONSIDERING PORTABILITY COVERAGE" SECTION ON PAGE 1 OF THIS FORM, I CERTIFY THAT NEITHER I NOR MY DEPENDENTS HAVE AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. I UNDERSTAND UNUM IS RELYING ON THIS CERTIFICATION AS A MATERIAL CONDITION TO ITS AGREEMENT TO PROVIDE COVERAGE.

If Unum determines that an injury or sickness has a material effect on life expectancy, as of the date portable coverage was elected, benefits may be reduced to the amount of coverage available under the current policy's conversion privilege.

| | | |
|--------------------|----------------------------|-------------------------|
| Insured Signature: | Today's Date (mm/dd/yyyy): | Insured's Email Address |
|--------------------|----------------------------|-------------------------|

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.



PORTABILITY BENEFICIARY DESIGNATION FORM

2211 Congress Street
Portland Maine 04122
Phone: 1-800-421-0344
Fax: 207-575-2993

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper.

PART 1: Information About You

Name (Last Name, Suffix, First Name, MI) Social Security Number - -

Policy Number Division

PART 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

| Name & Address | Telephone Number | Relationship | Social Security Number | Date of Birth | Percent |
|----------------|------------------|--------------|------------------------|---------------|------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Total Must Equal 100% |

PART 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

| Name & Address | Telephone Number | Relationship | Social Security Number | Date of Birth | Percent |
|----------------|------------------|--------------|------------------------|---------------|------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Total Must Equal 100% |

PART 4: Signature

X

Signature _____
Date

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HOW TO CALCULATE YOUR PORTABILITY PREMIUM PAYMENT

| | | | | | | | | | | | | | |
|--|---|--|--------|--|-------------|------------------------|-------------------|---------------------------------|-------------|---------------------------------|---------------------|--------|-------|
| <p>Calculate Your Premium Payment</p> <p>1. Find your rate on the rate table under appropriate tobacco use, if applicable. The rate is based on your age at the time your coverage terminates or is reduced.</p> <p>Note: You will qualify for non-tobacco premium rates if you have not used any tobacco products within the last 12 months.</p> <p>Your life insurance rates will continue to increase with age, every 5 years (for example, at age 50, 55, 60 etc.).</p> | <p>Base Rate Per \$1,000 of Coverage _____</p> | | | | | | | | | | | | |
| <p>2. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.</p> <p>Note: You may be eligible to increase your coverage which would require Evidence of Insurability subject to maximums outlined in your former group insurance policy.</p> | <p>Amount of Coverage _____</p> | | | | | | | | | | | | |
| <p>3. a. Base Rate Per thousand dollars of coverage:</p> <p>b. Number of thousand dollars you want:</p> <p>c. Multiply a. by b.:</p> <p>d. Mode you would like to pay</p> <p style="padding-left: 20px;">quarterly = 3</p> <p style="padding-left: 20px;">Semi-annual = 6</p> <p style="padding-left: 20px;">Annual = 12</p> <p>e. TOTAL c. and d. This is your premium</p> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Base Rate</td> <td style="width: 50%;">_____</td> </tr> <tr> <td># of \$1,000 Units</td> <td>x _____</td> </tr> <tr> <td>Base Rate X # of Units</td> <td>_____</td> </tr> <tr> <td>Mode Numeric</td> <td>x _____</td> </tr> <tr> <td> </td> <td></td> </tr> <tr> <td>*TOTAL</td> <td>_____</td> </tr> </table> | Base Rate | _____ | # of \$1,000 Units | x _____ | Base Rate X # of Units | _____ | Mode Numeric | x _____ | | | *TOTAL | _____ |
| Base Rate | _____ | | | | | | | | | | | | |
| # of \$1,000 Units | x _____ | | | | | | | | | | | | |
| Base Rate X # of Units | _____ | | | | | | | | | | | | |
| Mode Numeric | x _____ | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| *TOTAL | _____ | | | | | | | | | | | | |
| <p>*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding</p> | | | | | | | | | | | | | |
| <p>Example:</p> <p>1. A 44 year old person decides to continue \$25,000 of coverage</p> <p>2. The person wishes to pay premiums annually</p> <p>3. The monthly rate for a 44 year old is \$.510 per \$1,000 of coverage</p> <p>4. Calculate premiums:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">a. Base rate per thousand dollars of coverage:</td> <td style="text-align: right;">\$.510</td> </tr> <tr> <td>b. Number of thousand dollar units you want:</td> <td style="text-align: right;">x <u>25</u></td> </tr> <tr> <td>c. Multiply a. by b.:</td> <td style="text-align: right;">\$12.75 (Monthly)</td> </tr> <tr> <td>d. Multiply c. by 12 for annual</td> <td style="text-align: right;">x <u>12</u></td> </tr> <tr> <td>e. TOTAL. This is your premium.</td> <td style="text-align: right;">\$153.00 (Annually)</td> </tr> </table> | | a. Base rate per thousand dollars of coverage: | \$.510 | b. Number of thousand dollar units you want: | x <u>25</u> | c. Multiply a. by b.: | \$12.75 (Monthly) | d. Multiply c. by 12 for annual | x <u>12</u> | e. TOTAL. This is your premium. | \$153.00 (Annually) | | |
| a. Base rate per thousand dollars of coverage: | \$.510 | | | | | | | | | | | | |
| b. Number of thousand dollar units you want: | x <u>25</u> | | | | | | | | | | | | |
| c. Multiply a. by b.: | \$12.75 (Monthly) | | | | | | | | | | | | |
| d. Multiply c. by 12 for annual | x <u>12</u> | | | | | | | | | | | | |
| e. TOTAL. This is your premium. | \$153.00 (Annually) | | | | | | | | | | | | |

Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.

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I (each of the premium payors whose signature appears on the next page) have **carefully read** the terms of this authorization, and I **understand** and **agree** that:

- 1) This Authorization applies to coverage provided under the policy listed above and to any coverage subsequently added.
- 2) My signature on the next page reflects my intent that my account be debited by the Company in the amount necessary to pay premium.
- 3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.
- 4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage.
- 5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.
- 6) No premium shall be deemed paid until the Company receives payment at its Home Office.
- 7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.
- 8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to Unum.
Exception: The Company may terminate this Agreement, by providing written notice thereof, in the event that, within any period of twelve consecutive months, two or more premium debits are not paid upon presentation, or if any time the Company is required to refund to the bank any amount paid pursuant to this Authorization.
- 9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.
- 10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Please retain a copy of this form for your records

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