GROUP TERM LIFE PORTABILITY APPLICATION - EMPLOYEE

ReliaStar Life Insurance Company
New Business, PO Box 122, Minneapolis, MN 55440-0122
Phone: 800-955-7736

IMPORTANT NOTE: The Employer and Employee must complete all pertinent information on the following pages.
MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.
Return the completed form to the address shown above.

EMPLOYER / ADMINISTRATOR

Read the certificate to determine eligibility for portability. Complete and sign Page 1 of this Portability Application form. Send this form to the Employee to complete the remaining pages. Include copies of beneficiary designations and assignments.

Employer or Group Name Goose Creek Consolidated Independent School District

Group Policy Number 747963 Account Number 0001

Hire Date _____ Annual Salary at Termination $_____

Employee Name _____ Employee Birth Date _____

Date Last Worked _____ Coverage Termination Date _____

CURRENT COVERAGE INFORMATION

Employee Basic Life Insurance $_____ Coverage Effective Date _____

Employee Basic AD&D Insurance $_____ Coverage Effective Date _____

Employee Supplemental Life Insurance $_____ Coverage Effective Date _____

Employee Supplemental AD&D Insurance $_____ Coverage Effective Date _____

Spouse Supplemental Life Insurance $_____ Coverage Effective Date _____

Spouse Supplemental AD&D Insurance $_____ Coverage Effective Date _____

Children's Supplemental Life Insurance $_____ Coverage Effective Date _____

Children's Supplemental AD&D Insurance $_____ Coverage Effective Date _____

EMPLOYER COMMENTS

_____

_____

_____

EMPLOYER ACKNOWLEDGEMENT

I certify that all above information is true and correct according to the records of the employer.

This form will be: ☐ Handed ☐ Mailed ☐ Emailed to the employee on the following date _____

Authorized Signature _____ Date _____

Print Name _____ Title _____

Email _____ Employer Phone (_____) _____

Employee Name _____

Group Policy Number 747963 Account Number 0001

EMPLOYEE INFORMATION

Return the completed form to the address shown on Page 1. The insurer must receive this completed form within 31 days of the Coverage Termination Date. MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.

Employee Name _____ Employee Birth Date _____

Employee Billing Address _____ City _____ State _____ ZIP _____

Employee Phone (_____)_____ Employee SSN _____

PORTABILITY INFORMATION

The maximum amount allowed for portability is shown in the Portability Rider. Read the Portability Rider carefully to determine which coverage(s) are eligible for portability. You may only elect to port coverage that was in effect on the coverage termination date as shown on Page 1 of this Application. You will not be able to elect or increase ported coverage in the future.

Any life insurance amount that is not eligible for portability, or exceeds the maximum, may be converted to an individual policy. If you do not want to apply for portability and only want to receive information about conversion, you may skip the "Portability Elections" and "Evidence of Insurability" sections on this form.

Please contact the employer for copies of the certificate and riders describing coverage.

PORTABILITY ELECTIONS FOR EMPLOYEE COVERAGE

Employee Life Insurance **I Elect to Port *(Select one)*:** ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Will not exceed the lesser of $750,000 or 5 times Basic Yearly Earnings

Employee AD&D Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Employee Life must also be ported.
Will not exceed Employee Life amount ported.

PORTABILITY ELECTIONS FOR SPOUSE COVERAGE

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

You must port Employee coverage in order to elect portability of Spouse coverage.

Spouse Name _____ Spouse Birth Date _____

Spouse Life Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Will not exceed total Employee Life amount ported.
Maximum = $750,000

Spouse AD&D Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Spouse Life must also be ported.
Will not exceed total Spouse Life amount ported.
Will not exceed total Employee AD&D amount ported.

Employee Name _____

Group Policy Number 747963 Account Number 0001

PORTABILITY ELECTIONS FOR CHILDREN COVERAGE *(**Applies ONLY to currently Insured Children of the Employee as defined by the Children's Life Insurance Rider.** Include additional pages if space is required for more Children.)*

The use of "child" or "children" in this form means a person insured as a child under the Children's Life Insurance Rider.

You must port Employee coverage in order to elect portability of Children's coverage.

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Children's Life Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Will not exceed total Employee Life amount ported.
Maximum = $25,000

Children's AD&D Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Children's Life must also be ported.
Will not exceed total Children's Life amount ported.
Will not exceed total Employee AD&D amount ported.

Employee Name _____

Group Policy Number 747963 Account Number 0001

EVIDENCE OF INSURABILITY FOR PREFERRED RATES

Portability is available at the standard rates shown on the attached sheet. If you want to apply for the preferred rates for you or your spouse, then you and your spouse must complete the questions below. If any questions are unanswered, the standard rates will apply.

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

Answer the following questions:

1. Are you terminating active employment due to an inability to perform the regular duties of your occupation? **Employee:** ☐ Yes ☐ No

2. In the last 5 years have you received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

3. In the last 5 years have you been diagnosed, treated, or been given medical advice by a member of the medical profession for: any disorder or disease of the heart or blood vessels (excluding controlled high blood pressure); any kidney disease; any neurological disease or disorder; any liver disease; chronic lung disease (excluding asthma); cancer (excluding non-melanoma skin cancer); stroke; diabetes; rheumatoid arthritis; lupus; Crohn's disease; or ulcerative colitis?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

4. In the last 10 years have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

CONVERSION INFORMATION

If you want to receive life insurance conversion information because: (1) you do not want portability, or (2) your elected ported life amount(s) would be less than 100% of the terminating life coverage amount(s), then please check this box:

☐ Send Conversion Information

ACKNOWLEDGEMENT *(Return the completed form to the address shown on Page 1.)*

- I have read this form and all statements and answers that pertain to me.
- All statements and answers as they pertain to me are true and complete to the best of my knowledge and belief.
- I understand that the statements and answers will be used by the insurer to determine insurability.
- I have received ReliaStar Life Insurance Company's Consumer Privacy Notice and Insurance Information Practices Notice.

Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

➥ Employee Signature _____ Date _____

City and State _____

➥ Spouse Signature [1] _____ Date _____

City and State _____

➥ Owner Signature [2] _____ Date _____

City and State _____

[1] *Spouse Signature is required if Evidence of Insurability is completed above.*

[2] *Owner Signature is required only if the Owner is NOT the Employee.*