



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. There are many differences between portability and conversion, some key considerations are:

- **Portability** allows you, your spouse or child(ren) to continue (or "port") 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. **Eligibility to port coverage may be limited by restrictions per the terms in your Group Life certificate and Group Life Portability rider. Refer to your certificate or rider for details. Restrictions may include but are not limited to:**
 - **your age at the time of application;**
 - **either confinement to a home or hospital confinement or 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 policy you convert to will be different from the coverage you had under your employer's group life insurance policy. **Conversion does not have the same restrictions noted above for Portability**

If your Group Life Certificate and Group Life Portability rider restricts individuals with an INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY, please read the following to determine if you can elect coverage. 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 https://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 any of the restrictions outlined in your Group Life certificate and Group Life Portability rider, 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.

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.
- **Voluntary 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 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 of this election form and the Beneficiary Designation Form. Incomplete forms may be denied.
- Determine the amount of coverage you want to port. You may port an amount less than or equal to the amount you, your spouse or child(ren) had in force with your Employer. Ported coverage cannot exceed the lesser of 5x your earnings, the maximum allowed under your plan or \$750,000 across all Unum Life and AD&D coverages combined.
- 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.
- Please remember to (1) include your ACH form; (2) sign and date this election form; (3) designate a beneficiary; and (4) retain a copy of this entire form for your records.
- Mail completed forms to the address listed at the top of the election form.

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.
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TERM LIFE INSURANCE APPLICATION FOR 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(s) | Division | Class |
| Employee Legal Name (Last, First, MI): | | Employee Preferred Name: | | |
| 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: <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Retired <input type="checkbox"/> Reduced Hours (must be working) <input type="checkbox"/> Other, Explain _____ | | |
| Current Annual Earnings: | | | | |

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): | Sex: <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. Child eligibility may be 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 | | | | |

ALL PREMIUMS TO BE PAID MONTHLY VIA AUTOMATIC PAYMENT. Please complete and send in the enclosed Authorization and Agreement for Automatic Payments form with your application.

- ☐ I am opting out of monthly payments and want to pay:
☐ Quarterly (Every three months) ☐ Semi-Annually (Every six months) ☐ Annually (One time per year)

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 Life policy and Portability rider, if any, and/or Accidental Death and Dismemberment provisions under which this coverage is being offered, and is subject to satisfaction of the conditions provided therein.

Once an application for portability has been received and approved, portable coverage will be effective the day after coverage would have otherwise ended under the Employer's policy.

I certify that neither I nor my Spouse or Children are ineligible to port coverage per the terms of the portability restrictions in my Group Life certificate and Group Life Portability rider, if any. Restrictions may include, but not be limited to: home or Hospital Confinement; loss of 2 or more Activities of Daily Living; injury or sickness which has a material effect on life expectancy; duration of coverage under the Group Life Insurance certificate; or Spouse age. Please refer to your Group Life Insurance certificate and Portability rider for definitions and restrictions.

If Unum determines an applicant is ineligible to port coverage per the terms of the portability restrictions in the Group Life certificate and Group Life Portability rider, as of the date portable coverage was elected, benefits may be reduced to the amount of coverage available under the current policy's Conversion provision.

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

**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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.



HOW TO CALCULATE YOUR PORTABILITY PREMIUM PAYMENT

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|-----------|--|---|-----------------------|-------------------|---------------------------------|------------------------|---------------------------------|-------------------------------|------|---------|-------------|--|--|---------------|--|--|-----------------|--|--|-------------|--|--|---|--------|-------|
| Calculate Your Premium Payment 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. Note: You will qualify for non-tobacco premium rates if you have not used any tobacco products within the last 12 months. Your life insurance rates will continue to increase with age, every 5 years (for example, at age 50, 55, 60 etc.). | Base Rate Per \$1,000 of Coverage _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. 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. | Amount of Coverage _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table><tr><td>3. a. Base Rate Per thousand dollars of coverage:</td><td>Base Rate</td><td>_____</td></tr><tr><td>b. Number of thousand dollars you want:</td><td># of \$1,000 Units</td><td>x _____</td></tr><tr><td>c. Multiply a. by b.:</td><td>Base Rate X # of Units</td><td>_____</td></tr><tr><td>d. Mode you would like to pay</td><td>Mode</td><td>x _____</td></tr><tr><td>Monthly = 1</td><td></td><td></td></tr><tr><td>Quarterly = 3</td><td></td><td></td></tr><tr><td>Semi-annual = 6</td><td></td><td></td></tr><tr><td>Annual = 12</td><td></td><td></td></tr><tr><td>e. TOTAL c. and d. This is your premium</td><td>*TOTAL</td><td>_____</td></tr></table> <p>*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding</p> | | 3. a. Base Rate Per thousand dollars of coverage: | Base Rate | _____ | b. Number of thousand dollars you want: | # of \$1,000 Units | x _____ | c. Multiply a. by b.: | Base Rate X # of Units | _____ | d. Mode you would like to pay | Mode | x _____ | Monthly = 1 | | | Quarterly = 3 | | | Semi-annual = 6 | | | Annual = 12 | | | e. TOTAL c. and d. This is your premium | *TOTAL | _____ |
| 3. a. Base Rate Per thousand dollars of coverage: | Base Rate | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Number of thousand dollars you want: | # of \$1,000 Units | x _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Multiply a. by b.: | Base Rate X # of Units | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Mode you would like to pay | Mode | x _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Monthly = 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Quarterly = 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Semi-annual = 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Annual = 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. TOTAL c. and d. This is your premium | *TOTAL | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Example: 1. A 44 year old person decides to continue \$25,000 of coverage 2. The person wishes to pay premiums annually 3. The monthly rate for a 44 year old is \$.510 per \$1,000 of coverage 4. Calculate premiums: <table><tr><td>a. Base rate per thousand dollars of coverage:</td><td>\$.510</td></tr><tr><td>b. Number of thousand dollar units you want:</td><td>x <u>25</u></td></tr><tr><td>c. Multiply a. by b.:</td><td>\$12.75 (Monthly)</td></tr><tr><td>d. Multiply c. by 12 for annual</td><td>x <u>12</u></td></tr><tr><td>e. TOTAL. This is your premium.</td><td>\$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.



Unum Life Insurance Company of America
Authorization and Agreement for Automatic Payments
Drawn By and Payable To:
Unum Life Insurance Company of America (hereinafter referred to as "the Company")
2211 Congress Street, Portland, Maine 04122
1-800-421-0344 Fax number: 207-575-2993
email to: PortabilityConversion@unum.com

PLEASE PRINT

| BL#/POLICY NUMBER | INSURED NAME | SOCIAL SECURITY NUMBER |
|-------------------|--------------|------------------------|
| | | |
| | | |

☐ Please apply this to all my policies

1. Purpose for submitting this authorization form:

Type of Account:

- ☐ New Preauthorized payment plan
☐ Addition of new policy to plan

- ☐ Change in bank
☐ Change in account number

- ☐ Checking
☐ Savings

2. Current Address: _____

3. Name of Banking Institution: _____

4. Name on Bank Account: _____

5. Routing Number (9 digits): _ _ _ _ _

6. Account Number: _____

Refer to the sample check for help locating the Routing Number and Account Number. Attach or scan a Voided Check (optional).

Sample Check

John Doe
123 Main Street
Yourtown, ST 12345
1105

Date _____

Pay to the
Order of _____ \$ _____

_____ Dollars

Your First Bank
Yourtown, ST 12345
Your Branch

101010001 1000033338281 1105

APPLICANT INFORMATION FOR BANK:

You are hereby authorized, as a convenience to me, to pay and charge to my account any check or electronic fund transfer drawn on this account on the first of the month by and payable to the order of the company(s) indicated above for itself (themselves), provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or transfer shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice and you have had a reasonable time to act on it. I agree that you shall be fully protected in honoring any such check or transfer.

I further agree that if any such check or transfer be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

| | |
|-----------------------------------|------|
| Signature of Depositor | Date |
| Please print name as signed above | |

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



**THIRD PARTY AUTHORIZATION
PORTABILITY PROTECTION PLAN
Unum Life Insurance Company of America
Unum Insurance Company
2211 Congress Street
Portland, ME 04122
Attention: Portability/Conversion Unit
Fax: 207-575-2993**

For toll-free assistance call: 1-800-421-0344

| | | | | | | | | |
|-------------------|-----|--|--|--|--|--|--|--|
| POLICY OWNER NAME | BL# | | | | | | | |
| | BL# | | | | | | | |

| | | |
|-------------------------------|----------------------------------|--------------|
| AUTHORIZED INDIVIDUAL(S) NAME | Relationship to the Policy Owner | PHONE NUMBER |
| | | |
| | | |

I authorize Unum Group, its subsidiaries and affiliates* and duly authorized representatives ("Unum") to disclose the following insurance plan, policy billing and beneficiary information to the person(s) or organization(s) listed above, for the purpose of assisting me with my insurance coverage:

- Information regarding my coverage, including policy provisions and riders;
- Information regarding premium calculation, invoicing and payments; and
- Name(s) of designated beneficiaries (if applicable).

This authorization does not alter any prior designation made under any law protecting against unintentional lapse of coverage.

This authorization does not allow the authorized individual(s) or organization(s) to make any changes to my coverage, policy, riders, beneficiary designations, or assignments under my policy.

This Authorization does not allow Unum to share claim or health information including, but not limited to, my medical condition, diagnosis, treatment, or pre-existing condition information; the names of my physicians and other medical providers; or benefit amounts paid to me or on my behalf.

Unum will rely on this authorization until I revoke it in writing.

Unum may provide information in writing, electronically, or by telephone (including voice mail messages).

CERTIFICATION

- **I understand that once information is disclosed to the named authorized Individuals or Organizations, it may no longer be protected by federal privacy regulations.**
- I am not required to sign this authorization and Unum may not condition payment of claims on whether I sign this authorization.
- I am entitled to receive a copy of this authorization.
- I may revoke this authorization in writing at any time, except to the extent that Unum has relied on the authorization prior to notice of revocation.

Policy Owner Signature

Date Signed

Print Name

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life Accident Insurance Company and Provident Life and Casualty Insurance Company.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries

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