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 2 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 2 and the Beneficiary Designation Form on page 3. 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 by ACH form or check with this election form within 31 days from the date your coverage ends.
- Please remember to (1) include your ACH form or initial 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

Employee Name (Last, First, MI):

Policy Number | Division | Class

Date Coverage Ends (mm/dd/yyyy):

Current Annual Earnings:

Insured on disability or sick leave when terminated?
☐ Yes* ☐ No
*If Yes, date premium paid to:

Reason for Loss of Coverage:
☐ Terminated Employment
☐ Retired
☐ Reduced Hours (must be working)
☐ 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:
☐ Male ☐ 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? ☐ Yes ☐ No

Has your spouse used tobacco products in the past twelve months? ☐ Yes ☐ 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 by check or money order (made payable to Unum) with the following option:
☐ 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 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.

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 ☐

BL Number
BL ☐☐☐☐☐☐☐

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**

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 _____

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	_____

*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding

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:

a.	Base rate per thousand dollars of coverage:	$.510
b.	Number of thousand dollar units you want:	x 25
c.	Multiply a. by b.:	$12.75 (Monthly)
d.	Multiply c. by 12 for annual	x 12
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

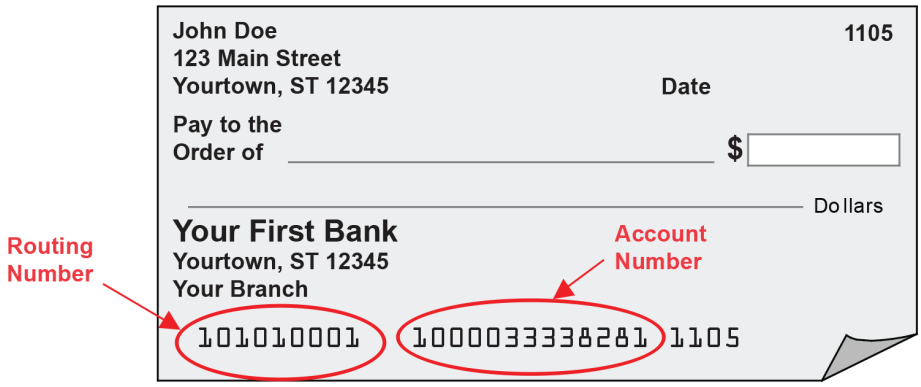
1. Purpose for submitting this authorization form:
   ☐ New Preauthorized payment plan ☐ Change in bank
   ☐ Addition of new policy to plan ☐ Change in account number

   Type of Account:
   ☐ 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



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