LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE

Unum Life Insurance Company of America (Unum)
Portability/Conversion Unit
2211 Congress Street, Portland, ME 04122
1-800-421-0344

You may be eligible to continue your Life coverage. To apply, you must complete this form and send it to Unum with your initial premium payment within 31 days after your group insurance coverage ends. **You are not eligible to apply for portable coverage for yourself and your dependents if you have a medical condition which has a material effect on life expectancy. Also, any dependent is not eligible for portable coverage if he or she has a medical condition which has a material effect on life expectancy.** If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage.

(Please print in ink)

TO BE COMPLETED BY THE EMPLOYER

Company Name:	Group Policy Number/Division Number:
Insured on disability/sick leave when terminated? ☐ Yes ☐ No	Date Coverage Ended (mm/dd/yyyy):
Reason for Loss of Coverage:	Current Annual Earnings:

Policyholder Signature _____ Date _____

Policyholder Telephone _____ Policyholder Email _____

In addition, please complete the current Group Life fields in the section below.

TO BE COMPLETED BY THE APPLICANT

Insured Name (last, first, initial)	Home Telephone #:
Insured Mailing Address (Street, PO Box, City, State, Zip)	Work Telephone #:

Social Security Number	Date of Birth (mm/dd/yyyy)	Have you used tobacco products in the last 12 months? ☐ Yes ☐ No	Sex ☐ Male ☐ Female

Select a premium payment option below. Please obtain your portability premium rates from your plan administrator and mail your initial premium payment, along with this election form, to the address shown above. **Make your check or money order payable to Unum.**

Select a premium payment option: ☐ Quarterly (monthly premium x3) ☐ Semi-Annually (monthly premium x6) ☐ Annual (monthly premium x12)

Please complete the information below. You may keep the same level of coverage or decrease coverage. You may also increase coverage or add dependents (if policyholder's plan has dependent coverage) subject to medical evidence of insurability. Note: For specific plan maximums, plan minimums, rounding rules and reduction formulas refer to your group certificate booklet.

	Yourself	**Spouse**	**Child**
Current Group Life Amount:	_____	_____	_____
Requested Portability Amount:	_____	_____	_____

Spouse Name: _____ Spouse date of birth: _____

Spouse Social Security No.: _____

Name and Address of Beneficiary: _____ **Relationship to you:** _____

_____

Social Security No. of Beneficiary: _____ **Date of Birth of Beneficiary:** _____

I understand and agree to the following:

1. 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 under which this coverage is offered and is subject to satisfaction of the conditions provided therein.
2. I CERTIFY THAT NEITHER I NOR MY DEPENDENTS FOR WHOM I AM ELECTING COVERAGE HAVE A MEDICAL CONDITION WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. I UNDERSTAND THAT UNUM IS RELYING ON THIS CERTIFICATION AS A MATERIAL CONDITION TO ITS AGREEMENT TO PROVIDE THIS PORTABILITY COVERAGE.
3. If Unum determines at a later date that I was not eligible due to such a medical condition on the date portability coverage was elected for me or my dependents, any life benefits payable will be reduced to the amount of whole life coverage that my or my dependents' premium would have purchased under the whole life policy offered through the Conversion Privilege.
4. Portability coverage will become effective the day after your group coverage terminates subject to Unum receiving a completed election form and the first premium within 31 days from the date your group coverage terminates.

Note: *If you have any questions concerning your or your dependent's eligibility for portability coverage, please contact us at 1-800-421-0344.*

If no dependent coverage is available under your group plan then any reference to "dependent" coverage is not applicable.

Insured Signature _____ Date (mm/dd/yyyy) _____ Email Address _____