GROUP BENEFIT SOLUTIONS

APPLICATION FOR PORTABILITY OF TERM LIFE INSURANCE

FOR FORMER EMPLOYEES & THEIR DEPENDENTS

Underwritten by
Life Insurance Company of North America (LINA)

Section A of this Application is to be completed by the Employer, all other sections are to be completed by the Former Employee*, for themselves, their Spouse and Children, as applicable, to elect to continue the Term Life Insurance coverage they had under a group policy.

Important Notes

- **A Former Employee is an Employee who has lost coverage under the group through Retirement, Termination of Employment, or other means, and is no longer an Active Employee with this group.*
- *The term `Spouse' used throughout this application will include Domestic Partners as defined in the group policy.*
- *Depending on the facts and circumstances of your unique situation, as well as the terms and conditions of the applicable policy(ies), the options outlined in the application may not all be available to you. Please refer to your certificate(s) of insurance for further details.*

How Much Time Do I Have to Submit My Application?

You will have the **later of** 31 days from your group coverage end date or 15 days from your date of your notification, to submit this completed application to us.

However, under no circumstances will the 15-day extension go beyond 91 days from your coverage end date.

Your date of notification is the date entered by your Former Employer in the Verification box in Section A of this application. If Section A is left blank, you should still submit your application.

The effective date of coverage issued, will be the first day of the month following your group coverage end date.

Standard - LINA
874201 Rev. 07/2023

Employee Name _____ **Social Security Number** _____

CLEAR FORM

Section A: Employer Verification

INSTRUCTIONS: *Employer must complete this section.*

If the group coverage cancelled because of group cancellation of contract, Portability is not an option.

Please print (preferably in black ink)

Employer Name	**Group Policy Number**	**Group Class Number**
Name of Employee	**Date of Hire**	**Last Date Worked**

Employment Termination Date	**Coverage End Date**	**Salary** (as of Last Date Worked)

Effective Date of Salary	**Reason for Loss of Coverage**
	☐ Retirement ☐ Termination of Employment ☐ Disability ☐ Other (Describe):

Basic Life Coverage	**Employee**	**Spouse**	**Child**
Group Coverage Effective Date (month/day/year)			
Premium Paid Through Date (month/day/year)			
Basic Life Coverage Amount			
Has a Terminal Illness benefit been paid?	☐ Yes ☐ No	☐ Yes ☐ No	N/A
If the Coverage has been reduced due to age, please enter the reduced amount.			N/A
Voluntary Life Coverage	**Employee**	**Spouse**	**Child**
Group Coverage Effective Date (month/day/year)			
Premium Paid Through Date (month/day/year)			
Voluntary Life Coverage Amount			
Has a Terminal Illness benefit been paid?	☐ Yes ☐ No	☐ Yes ☐ No	N/A
If the Coverage has been reduced due to age, please enter the reduced amount.			N/A

Verification of the Information Above was provided by:

Employer/Policyholder Signature:	Date: (Month/Day/Year)

Email Address:	Telephone Number:

Employee Name _____ **Social Security Number** _____

Section B: Insured Information

INSTRUCTIONS: *Sections B, C, D & E should be completed by the Former Employee.*
Please print (preferably in black ink)

Employer Name	**Group Policy Number**	**Group Class Number**

Employee Name (First)	(Last)	(Middle)

Address	**City**	**State**	**Zip Code**

Date of Birth	**Social Security Number**	**Phone Number and/or Email Address**

Reason for Loss of Coverage	**Were You Disabled on Your Coverage End Date?**
	☐ Yes ☐ No

Spouse's Name (First)	(Last)	(Middle)

Date of Birth	**Social Security Number**	**Phone Number and/or Email Address**

Children will be eligible if they meet the definition of a Dependent Child in the policy.

If you have at least one eligible child you intend to request coverage for, please complete the information below. If you need more space, please complete a separate page using this format and add the appropriate policy number, the date and your signature.

Child's Name	**Date of Birth**	**Social Security Number**
1.		
2.		

Section C: Coverage Elections

INSTRUCTIONS: *In this section, the Former Employee must elect the coverage amounts (Basic and/or Voluntary Life) they want to continue under a Portability option in the group policy. Basic coverage is coverage that the Employer provided at no cost and Voluntary coverage is `supplemental' coverage the Employee was paying for through payroll deductions.*

Portability on the Basic and/or Voluntary coverage varies by Employer and may not be one of your options. Age and Policy Plan limitations may exist which could limit your and/or your Dependent's eligibility to continue coverage with Portability. If you or your Dependents do not meet the age, or other requirements for Portability, you may be able to convert this coverage to an individual whole life policy offered by New York Life Group Benefit Solutions (NYL GBS) at the time. Please consult your Certificate of Insurance.

Each person coverage is being elected for, must have had coverage under the group policy.

Employee Basic Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Employee Voluntary Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Spouse Basic Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Spouse Voluntary Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Child Voluntary Life	☐ Continue Current Amount	☐ Other Amount: $ _____

Have you applied for any of the following benefits, either now or previously (check all that apply)?

☐ Conversion to an Individual Policy	☐ Waiver of Premium (if disabled)	☐ Terminal Illness Benefit
Application date:	Application date:	Application date:

Employee Name _____ **Social Security Number** _____

IMPORTANT COVERAGE NOTES:

You may keep your coverages the same, decrease or increase, as available in the policy. If Increases are available in the policy, they are subject to proof of good health and approval by the insurance carrier.

If a Terminal Illness Benefit (TI) was paid under the group policy for any coverage listed for an insured, the full amount of group coverage without the TI reduction must be completed on this application to receive the remaining balance.

Any age-related reduction provisions that were in the group policy, may continue to apply. The Conversion Privilege related to any partial loss of coverage remains subject to the terms of the group policy.

Please check your Certificate of Insurance or contact us at the number located at the end of this application to help with any of these questions.

Section D: Beneficiary Designations

INSTRUCTIONS: *Any beneficiary designations which you made under the group life insurance policy will not automatically carry forward.*

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries.

If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares.

Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

If electing two or more beneficiaries for one Insured, the percentages must equal 100%.

Please print (preferably in black ink)

Beneficiary Name (For Employee Coverage)	**Percentage** ***Total 100%***	**Social Security Number**	**Date of Birth**	**Relationship**
	%			
	%			
Beneficiary Name (For Dependent Spouse Coverage)	**Percentage** ***Total 100%***	**Social Security Number**	**Date of Birth**	**Relationship**
	%			
	%			
Beneficiary Name (For Dependent Children Coverage)	**Percentage** ***Total 100%***	**Social Security Number**	**Date of Birth**	**Relationship**
	%			
	%			

If you need additional space to indicate your beneficiary designations, attach a separate page using the above format including the appropriate policy number, the date, and your signature.

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs in the space provided below.

Spouse's Signature: _____	**Date:** (Month/Day/Year) _____

Employee Name _____ **Social Security Number** _____

Section E: Agreements & Authorization

INSTRUCTIONS: *If the ownership of this coverage had been previously assigned to someone other than the insured, it is the Owner that should sign below accordingly and provide the assignment documentation with the application.*

Your signature and date attest to your agreement of the following information.

To the best of my knowledge and belief all written, telephonic and electronic information I gave is true and complete. The conditions for the requested Insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions**.**

Employee/Owner's Signature:	**Date:** (Month/Day/Year)
_____	_____

Caution: *Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.*

Section F: Portability Rate Table

Note: *The Portability Rate for Dependent Children is the same rate as it was under the group.*

This chart is intended as a guide to provide an estimated cost of the coverage.

Portability Rates

Rates shown below are per $1,000 of coverage per month

(Employee and Spouse)

Attained Age	Rate per $1,000
Under 20	$.153
20 to 24	$.144
25 to 29	$.153
30 to 34	$.177
35 to 39	$.190
40 to 44	$.243
45 to 49	$.384
50 to 54	$.726
55 to 59	$1.347
60 to 64	$2.461
65 to 69	$4.065
70 to 74	$6.143
75 to 79	$9.792
80 to 84	$15.523
85 to 89	$24.106
90 to 94	$36.119
95 to 99	$51.278

While this table of rates shows premium rates through age 99, eligibility for continuance of coverage will be as provided under the terms of the policy under which life insurance is being continued, including any age limits contained in the policy.

CLICK TO PRINT

How Do I Get Billed?

Portability has standard due dates on the first of January, April, July or October. If your effective date does not align with one of these months, your initial bill may be higher. Electronic Fund Transfer (EFT) for monthly payments is also available once your certificate is current. Thereafter, you will receive your bill approximately 30 days in advance of the due date. To keep your coverage in force, you must pay your premiums as required.

When Does This Coverage End?

Coverage will end as provided in the Portability Option of the group policy. Age-related termination of coverage may apply. When your coverage under the Portability Option ceases (for reasons other than non- payment of premium), you may be able to convert this coverage within a specified timeframe to an individual whole life policy then offered by the Insurance Company (see your Certificate of Insurance for details).

How Do I Apply and/or Ask Questions?

Mail your completed & signed application to:

Amwins Group Benefits, LLC.
P.O. Box 152501
Irving, TX 75015-2501

Fax Number: 469-417-1675
E-Mail: AGBLSouth-NYLCustomerService@amwins.com

For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.