



**Application for Portability of Basic and Voluntary Term Life Insurance
(Employee Only Basic & Employee, Spouse or Domestic Partner and Child/ren Voluntary)**

Underwritten by Life Insurance Company of North America
(Herein called the Insurance Company)

IMPORTANT REMINDERS

- 1) If coverage terminates due to group policy cancellation, portability is not an option.
- 2) If you have received an Accelerated Death Benefit (ADB) (Example: Terminal Illness) under the group policy, you must elect the full amount of group coverage without the ADB reduction.
- 3) A copy of the letter notifying you of your conversion and portability right must be submitted with your completed form. If a copy is not provided, processing could be delayed.
- 4) If you or any of your dependents had to submit medical evidence of good health for any part of the Life Insurance amount, please provide a copy of the approval letter, and/or any other related documentation that you received in regards to the decision rendered.

**** THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE.
HOWEVER, IF THE OWNERSHIP OF THE LIFE INSURANCE HAS BEEN ASSIGNED TO A THIRD PARTY,
THE ASSIGNEE MUST COMPLETE THIS FORM.
PLEASE COMPLETE EACH SECTION THAT FOLLOWS.**

SECTION A Please print (preferably in black ink).

EMPLOYEE INFORMATION

Employer's Name: _____ Group Policy Number: _____
 Employee's Name (First): _____ (Last): _____ (Middle Initial): _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____
 Birth date: _____ Social Security Number: _____
(Month/Day/Year)
 Day Phone: _____ Evening Phone: _____

1. Last Day Worked: _____ Were you disabled on your coverage end date? Yes No
(Month/Day/Year)

2. Reason for leaving work: _____

3. If you wish to continue your coverage, please check the appropriate box for each type of coverage listed:

Basic Coverage

Voluntary Coverage

- | | |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Continue amount of coverage currently in force | <input type="checkbox"/> Continue amount of coverage currently in force |
| <input type="checkbox"/> Decrease the coverage amount to \$ _____
<small>(Units of \$1,000)</small> | <input type="checkbox"/> Decrease the coverage amount to \$ _____
<small>(Units of \$1,000)</small> |
| <input type="checkbox"/> Increase your coverage to \$ _____
<small>(Units of \$1,000)</small> | <input type="checkbox"/> Increase your coverage to \$ _____
<small>(Units of \$1,000)</small> |

See "Coverage Increases" under the General Information section of this form.

4. Have you applied for: (Check all that apply)

- | | |
|-------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Conversion to an individual policy | Application Date: _____
<small>(Month/Day/Year)</small> |
| <input type="checkbox"/> Waiver of Premium | Application Date: _____
<small>(Month/Day/Year)</small> |
| <input type="checkbox"/> Accelerated Death Benefit (ADB) | Application Date: _____
<small>(Month/Day/Year)</small> |

Note: The portability death benefit amount will be reduced by the amount of coverage paid under the ADB Claim (Example Terminal Illness), however, the portability premiums may be required to be paid on the full amount of coverage in place prior to the reduction.

Employee Name: _____ Social Security Number: _____

SPOUSE or DOMESTIC PARTNER INFORMATION

Note: If the Employee is applying to continue coverage for a Spouse or Domestic Partner as defined under the group policy, the Employee must answer questions 1 and 2 below.

Spouse's or Domestic Partner's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Birth date: _____ Social Security Number: _____
(Month/Day/Year)

Day Phone: _____ Evening Phone: _____

1. If you wish to continue coverage for your Spouse or Domestic partner, please check the appropriate box:

Voluntary Coverage

- Continue amount of coverage currently in force
- Decrease the coverage amount to \$ _____
(Units of \$1,000)
- Increase your coverage to \$ _____
(Units of \$1,000)

See "Coverage Increases" under the General Information section of this form.

2. Has your Spouse or Domestic Partner applied for: (Check all that apply)

- Conversion to an individual policy Application Date: _____
(Month/Day/Year)
- Accelerated Death Benefit (ADB) Application Date: _____
(Month/Day/Year)

Note: The portability death benefit amount will be reduced by the amount of coverage paid under the ADB Claim (Example Terminal Illness), however, the portability premiums may be required to be paid on the full amount of coverage in place prior to the reduction.

CHILD INFORMATION

Note: If the Employee is applying to continue coverage for a Dependent Child or Children, the Employee must complete the information below. Please note, you cannot continue child coverage unless each child meets the age and dependency requirements as defined in the group policy.

Do you wish to continue coverage for your dependent child(ren)? Voluntary Coverage Yes No

Dependent Child's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Birth date: _____ Social Security Number: _____
(Month/Day/Year)

Phone Number: _____

Dependent Child's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Birth date: _____ Social Security Number: _____
(Month/Day/Year)

Phone Number: _____

If you have additional children, attach, sign and date a separate sheet of paper using the format above.

Employee Name: _____ Social Security Number: _____

BENEFICIARY INFORMATION

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).

Beneficiary Name (Employee Coverage)	Percentage Total: 100%	Social Security Number	Date of Birth (Month/Day/Year)	Relationship
Beneficiary Name (Spouse or Domestic Partner Coverage)	Percentage Total: 100%	Social Security Number	Date of Birth (Month/Day/Year)	Relationship
Beneficiary Name (Children Coverage)	Percentage Total: 100%	Social Security Number	Date of Birth (Month/Day/Year)	Relationship

If you need additional space to indicate your beneficiary designations, attach a separate piece of paper 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 Signature: _____ Date: _____

SECTION B Complete this section only if the current Owner is other than the Employee.


Owner - The Owner is the person who has the right to assign, surrender, and exercise all other rights contained in the contract. If no other Owner is designated, the Employee shall be the Owner. All correspondence and premium notices will be mailed to the Owner. If you wish to designate someone other than yourself as the owner, an assignment form must be completed.

Owner Name: _____ Tax I.D./Social Security Number: _____

Street Address: _____ Telephone Number: _____

City: _____ State: _____ Zip Code: _____

Please sign and date here
If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).


 Owner's Signature: _____ Date: _____
(Must be signed by Owner if other than employee.) *(Month/Day/Year)*

Read the Agreements and Authorization section that follows. Sign and date the form in the spaces provided.

***** AGREEMENTS AND AUTHORIZATION *****

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.

Please sign and date here
If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).

 Employee'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.

GENERAL INFORMATION

1. **Eligibility** - Age limitations may exist which will limit your eligibility to continue your coverage. These limitations may be reviewed in your originally issued Certificate. If you do not meet the age requirements to continue your coverage, you can convert this coverage to an individual whole life policy then offered by the Insurance Company.
2. **Rates** - Please note that rates under the Portability Option may be higher than those you paid previously, and they are subject to change. If you would like an estimated premium before applying for coverage, please call 1-800-423-1282.
3. **Deadline** - You have 62 days from the coverage end date to exercise the Portability Option. If notification of this right is given more than 31 days prior to the end of the 62-day period, you will have 31 days from the date of your letter notifying you of your options, whichever is later. In no event will this period be extended beyond 105 days. A copy of your notification letter must be included when submitting your application.
4. **Effective Date** - The effective date of your continued coverage will be the first day of the month following the coverage end date as reflected in your letter notifying you of your portability and conversion options.
5. **Billing** - You will be billed on a quarterly basis. After the initial bill, you will receive your bill approximately 30 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly.
6. **Coverage Increases** - You may be able to increase your coverage in accordance with the terms of the group policy. If coverage increases are allowed under your plan (see your Certificate for details), you must provide evidence of good health and be approved by the Insurance Company. Please indicate in "Section A" of this application if you want to increase your coverage for yourself and/or your Spouse or Domestic Partner; an Evidence of Insurability Form will be mailed to you.
7. **Coverage Decreases** - The group policy may limit dependent coverage (for your Spouse or Domestic Partner or your Children) to a percentage of the Employee's coverage amount. If you voluntarily elect to decrease your coverage, dependent coverage may also be required to be reduced at the same time if your plan contains this type of limitation (see your Certificate for details).
8. **Coverage Reductions** - Any age-related reductions in insurance may continue to apply. The Conversion Privileges related to any partial loss of coverage remains subject to the terms of the group policy (see your Certificate for details).
9. **Coverage Terminations** - 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 group policy ceases (for reasons other than non-payment of premium), you may be able to convert this coverage within the specified timeframe to an individual whole life policy then offered by the Insurance Company (see your Certificate for details).

**Mail your completed & signed form, along
with a copy of your notification letter to:**

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

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