First Unum Life Insurance Company

unum

LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE

Portability Unit
2211 Congress Street, Portland, ME 04122
1-800-421-0344

If your group coverage ends due to employment termination, retirement or reduction in hours, you may be eligible for portable coverage. To apply, you must complete this form and send it to Unum within 31 days after your group insurance coverage ends. If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage. Ask your employer for a conversion application form (which includes cost information).

(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 and AD&D 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: ☐ 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:	_____	_____	_____
Current Group AD&D Amount:	_____	_____	_____
Requested AD&D Amount:	_____	_____	_____

Spouse Name: _____ Spouse date of birth: _____

Spouse Social Security No.: _____

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

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 and/or accidental death and dismemberment insurance coverage under which this coverage is offered and is subject to satisfaction of the conditions provided therein.
2. Portability coverage will become effective the day after your group coverage terminates subject to Unum receiving a completed election form 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 or accidental death and dismemberment coverage is available under your group plan then any reference to "dependent or accidental death and dismemberment" coverage is not applicable.

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

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First Unum Life Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Life Insurance Company

As part of your enrollment for insurance with Unum, please complete this form and provide it to your Plan Administrator. Also, in order to effectively identify and locate beneficiaries and help ensure that benefits are distributed appropriately upon the death of an insured or additional named insured, we request information in writing from time-to-time, including when we become aware of a change regarding you, your beneficiary(ies) or additional named insured of your life insurance coverage. Please fill in the requested information below.

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)		Social Security Number
Mailing Address	Telephone Number	Date of Birth

SECTION 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 4: Additional Named Insured/Spouse

Name (Last Name, Suffix, First Name, MI)		Social Security Number
Mailing Address	Telephone Number	Date of Birth

SECTION 5: Additional Named Insured/Spouse 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 6: Additional Named Insured/Spouse 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
					Total Must Equal 100%

SECTION 7: Signature

X _____ _____

Employee Signature **Date**

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