Portability of Voluntary Term Life Insurance

(Employee, Spouse, Child/ren)

Underwritten by Life Insurance Company of North America, a CIGNA company

Please print (preferably in black ink).

EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER.

Employer _____ **Policy #** _____

Name of Employee _____ Class (required) _____

Voluntary Coverage Amount that may be continued: Employee _____ Spouse _____ Child _____

Coverage Effective Date of Amount that may be continued: _____ *Month /Day/Year*

Last Day Worked: _____ *Month /Day/Year* Coverage Termination Date: _____ *Month /Day/Year* Employment Termination Date: _____ *Month/Day/Year*

Reason for loss of Group Insurance: *(not all reasons may qualify for portability)* Check only one.

☐ Termination of Employment ☐ Cancellation of Group Contract ☐ Change to Another Class

☐ Reduction in Benefit ☐ Retirement ☐ Disability ☐ Other _____

Date Notice Provided: _____ *Month /Day/Year*

Employer Signature _____ Date _____ *Month /Day/Year*

Note to Employer: ***Be sure to check the group policy regarding portability limitations and assignments. Notice must be provided to the Owner of this coverage. If ownership of coverage has been assigned, the Owner may be other than the employee or dependent.***

**** NOTE: THIS FORM IS TO BE COMPLETED BY THE OWNER OF THIS COVERAGE****

Employee Information

Please print (preferably in black ink).

Home Address _____ City _____ State _____ Zip _____

Gender ☐ Male ☐ Female

Day Phone _____ Evening Phone _____ Social Security # _____ Birthdate _____ Month/Day/Year

1. **If you wish to continue your coverage, please check the appropriate box for each type of coverage listed:**
   - ☐ Continue amount of coverage currently in force
   - ☐ Decrease the coverage amount to _____ (Units of $1,000)
   - ☐ Increase your coverage. *See item #5 in General Information*
2. **Have you smoked or used any form of tobacco in the last 12 months?** ☐ **Yes** ☐ **No**
3. **Have you applied for: (Check all that apply.)**
   - ☐ Conversion to an individual policy Application Date: _____ Month/Day/Year
   - ☐ Waiver of Premium Application Date: _____ Month/Day/Year
   - ☐ Accelerated Benefit/Terminal Illness Benefit Application Date: _____ Month/Day/Year

Spouse Information

Spouse's Name _____ Social Security # _____ Birthdate _____ Month/Day/Year

1. **If you wish to continue voluntary coverage for your spouse, please check one:**
   - ☐ Continue amount of coverage currently in force
   - ☐ Decrease the coverage amount to _____ (Units of $1,000)
   - ☐ Increase spouse coverage. *See item #5 in General Information.*
2. **Have you smoked or used any form of tobacco in the last 12 months?** ☐ **Yes** ☐ **No**
3. **Has your spouse applied for: (Check all that apply.)**
   - ☐ Conversion to an individual policy Application Date: _____ Month/Day/Year
   - ☐ Accelerated Benefit/Terminal Illness Benefit Application Date: _____ Month/Day/Year

Child/ren Information

Do you wish to continue coverage for your dependent child/ren? ☐ Yes ☐ No

Please note, you cannot port child coverage unless the child meets the age and dependency requirements as defined in the group policy.

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Employee Name _____ **Social Security #** _____

Beneficiary Information

You must specify a beneficiary(ies) by completing the section below. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each and the total must equal 100%. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

Beneficiary (Employee Coverage)	Percentage	Social Security #	Date of Birth *Month/Day/Year*	Relationship

Beneficiary (Spouse Coverage)	Percentage	Social Security #	Date of Birth *Month/Day/Year*	Relationship

Beneficiary (Children Coverage)	Percentage	Social Security #	Date of Birth *Month/Day/Year*	Relationship

Please sign here ☛ Employee's Signature _____ Date _____ *Month/Day/Year*

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 _____

City _____ State _____ Zip Code _____

Please sign here ☛ Owner's Signature _____ Date _____

(Must be signed by Owner if other than employee.) Month/Day/Year

General Information

1. **Eligibility –** Age limitations may exist which will limit your eligibility to continue coverage. These limitations may be reviewed in your certificate. If you do not meet the age requirements to continue your coverage, you can convert this coverage to any individual permanent policy then offered by the company.
2. **Rates** – Please note that rates for continued coverage will 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 31 days from the Coverage Termination Date to exercise the portability option. If you were not notified of this right at least 15 days prior to the end of the 31-day period, you will have 15 days from the date notice is given to apply for continued insurance. In no event will this period be extended more than an additional 60 days.
4. **Effective Date** – The effective date of your continued coverage will be the first day of the month following the Coverage Termination Date.
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 –** The benefit allows you to apply at any time for an increase in the amount of insurance you have in force. For yourself or your family and/or apply for spouse or family coverage at any time. You must provide satisfactory evidence of good health, and be approved by the insurance company. Please indicate on the front of this form if you want to increase your coverage for yourself or your spouse and an Evidence of Insurability Form will be mailed to you.
7. **Coverage Terminations and Reductions** – Any age-related reductions in insurance continue to apply. You will need to contact NEBCO at the address shown below when a child is no longer eligible for coverage (refer to your certificate for additional information). When your coverage under the group policy ceases for reasons other than non-payment of premium, you can convert this coverage to any individual permanent policy then offered by the company. Please contact NEBCO at the address shown below, and they will provide you with the appropriate forms, at any time you wish to cancel coverage for yourself, your spouse and/or children, please call NEBCO for instructions.

Complete this form, sign and date, and return to: NEBCO, 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.

Print Reset Form