# Lewisville ISD

## Exit Package: What Happens to Benefits when you Leave the District?

**CONTENTS**



The information on the following pages contains information and forms to assist with continuing eligible benefits when you are leaving employment with Lewisville ISD. Some of these benefits are "**portable**" and some are covered by "**COBRA**."

**PORTABLE** means that you can choose to pay the premiums directly to the contracted vendor and continue these benefits for you and your family members (if applicable).

**COBRA** is a U.S. Congress-passed Bill called Consolidated Omnibus Budget Reconciliation Act of 1985. The health benefit provisions of the law amends the Employee Retirement Income Security Act, the Internal Revenue Code, and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated. COBRA contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates.

Group health coverage for COBRA participants is generally more expensive than health coveragefor active employees, since usually the employer pays a part of the premium for active employees while COBRA participants typically pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage.

# Lewisville ISD Supplemental Benefits

| PLAN | VENDOR INFO | COBRA | PORTABLE AND/OR CONVERTIBLE | PLAN TERMINATES WHEN YOU DO | CAN NO LONGER CONTRIBUTE; BUT IT'S YOUR MONEY/ACCT | WHAT HAPPENS NEXT? |
|---|---|---|---|---|---|---|
| **Medical** | TRS 866.355.5999 | ✔ | | | | You will receive a letter from Bswift |
| **Vision** | Superior by MetLife 833.393.5433 | ✔ | | | | You will receive a letter from NBS after term date |
| **Dental** | MetLife 800.942.0854 | ✔ | | | | You will receive a letter from NBS after term date |
| **Disability Plan** | New York Life 888..842.4462 | | | ✔ | | Nothing, coverage stopsas of the date of your benefits termination with the district |
| **Term Life and AD&D** | Unum 800.421-0344 | | ✔ | | | Complete attached form and return to Unum within 31 days |
| **Legal Plan** | LegalEASE 800-248-9000 | | ✔ | | | You must call within 31 days to setup auto-payment |
| **Critical Illness** | Cigna 800.362.4462 | | ✔ | | | Complete attached form and return to Cigna within 31 days |
| **Hospital Cash Plan** | CHUBB 888.499.0425 | | ✔ | | | Complete the attached CHUBB portability form and return within 31 days |
| **Individual Life Insurance** | Texas Life 800-283-9233 | | ✔ | | | Fill out the attached forms and mail to Texas Life within 31 days |
| **Emergency Ambulance Service** | MASA 800.423.3226 | | ✔ | | | You can reach out to MASA for portability information |
| **Retirement Savings** | TCG Administrators 800.943.9179 | | | | ✔ | Your account will continue to be invested |
| **Flexible Spending Accounts (FSA)** | NBS 800.274.0503 | ✔ | | | | You will receive a letter from NBS after term date |
| **Health Savings Account (HSA)** | EECU 817.882.0800 | | | | ✔ | The HSA Account will continue to beinvested |
| **MDLIVE + Behavioral Health** | MDLIVE 888.365.1663 | | ✔ | | | Contact MDLIVE for individual rate and set up an individual plan |

# TRS Medical

**TRS Medical is convertible to COBRA**

TRS ActiveCare members are eligible for COBRA. The TRS ActiveCare COBRA Administrator at BSwift will send you a letter to your home via USPS to explain your options. If, after 45 days of leaving the district, you have not received information from BSwift, please call 833-682-8972.

# Dental and Vision Plans

**Dental and Vision are convertible to COBRA**

Like TRS ActiveCare above, your Superior by MetLife Vision and MetLife Dental are COBRA eligible. The Dental and Vision COBRA are administered through National Benefits Services. NBS the COBRA Administrator will send you a letter via USPS to explain your COBRA options and a payment coupon book after your separation from LISD. If after 45 days of leaving the district, you have not received information from the National Benefit Services, please contact LISD at 469-948-8104 or by email at benefits@lisd.net.

# Term Life and AD&D Plan by Unum

Your Term Life is both convertible and portable. To convert or port your plan you must first, have your employer complete and sign section 1 of either form. Once section 1 is complete by your employer, you need to complete the rest of the document and mail to Unum Life Insurance with your monthly premium payment within 31 days of your separation from employment. An information sheet has been provided to better explain your options on pages 6-8. The portability and conversion forms are on pages 9-16 (portability) and page 17-21 (conversion). If you have any questions, you can contact Unum Insurance at 800.421.0344.

# Legal Assistance Plan

**Legal Plan by LegalEASE**

You may continue your legal insurance by converting to an individual plan. Simply contact LegalEase within 31 days of your separation from employment to make payment arrangements. You can contact LegalEase at 888.416.4313

# Flexible Spending Account

**FSA is convertible to COBRA**

FSA Cobra is only available if the participant has unused funds and continues to contribute to the account during the plan year. If a participant leaves the district at the end of the plan year—the account ends, and no new elections can be made. For example, your termination date is 8/31 and you currently have a flex spending account that also ends 8/31, you cannot start a new account effective 9/1; or if your last day is 7/30, and your flex account ends 8/31 and you have funds left, you can contribute the final month of payments and use their account through 8/31. Keep in mind: It is a "use it or lose it" account.

# FICA, 457 and 403(b) Retirement Savings

**Retirement savings accounts continue to be invested**

Separation from employment is a qualifying event and thus allows you to remove your funds from your account if you wish. If you choose to keep your funds in your Retirement Savings Account, they will continue to be invested. You can also contact your Investment Provider directly to inquire about other investment options they offer.

# Health Savings Account (HSA)

**Health Savings Account continue to be invested**

Once you have established an HSA it is yours regardless of employment. Once you reach age 65 your funds can be withdrawn at any time and are only subject to ordinary income tax. However, you may avoid any tax by continuing to use the funds for qualified medical expenses. For those over age 65 premiums for Medicare Part A or B, Medicare HMO and employee premiums for employer sponsored health insurance can be paid from an HSA. For those electing COBRA Continuation Coverage your premium payments may also be paid from an HSA.

# Critical Illness Plan

### Critical Illness Plan by Cigna Insurance

You may continue this Critical Illness insurance by porting your coverage. You will need to complete the attached Cigna portability application on pages 21-23 within 31 days of separation of employment. Return completed form to: Cigna, P.O. Box 29230, Phoenix, AZ 85038-9920. You will continue with group rates, but rates may be subject to change. If you have other questions or need assistance completing the form, contact Cigna Customer Service Center at 800.754.3207.

# Hospital Cash Plan

### Hospital Cash Plan by CHUBB

You may continue this Hospital Cash insurance by porting your coverage. You will need to complete the attached CHUBB portability application on pages 24-27 within 31 days of your separation from employment. If you have any other questions, you can contact CHUBB directly at 800.499.0425

# Individual Life Insurance

### Individual Life by Texas Life Insurance

The rate of the individual life insurance you purchased is guaranteed to remain the same to age 100—and the policy remains intact until age 120. This policy is intended to provide coverage until your death. With individual life insurance, the policy is portable—so, regardless of your employment status, a benefit will be provided as long as premiums have been paid and the contract is in force when you die. Attached are 2 forms: the Request for Cash Surrender Form pages 28-29 and the Automatic Bank Draft Form page 30. Both forms must be filled out and submitted to Texas Life within 31 days of your separation of employment for you to retain your coverage. You can either mail the forms to: Texas Life at PO Box 830, Waco, TX 76703, fax forms to 254.745.6393, or call 800.283.9233 with questions.

# Emergency Ambulance Service

### Emergency Ambulance Service by MASA Assist

Moving this plan from payroll deduction to automatic bank withdrawal is easy. Simply call 800.643.9023 or visit www.masaassist.com and request the option to pay monthly with a credit card.

# Telehealth + Behavioral Health

### MDLIVE Telehealth + Behavioral Health

Please contact MDLIVE at 888.365.1663 for individual rate information and to set up an individual plan within 31 days of separation from employment

# Keeping your life insurance
# Decisions to make, steps to take

When your relationship with your employer changes — either because you're leaving the company, you've become disabled, or you're no longer eligible for coverage — you'll want to take steps to preserve your life insurance.

If your family's financial security and plans for the future — such as paying for college or staying in your home — are important to you, taking your life insurance with you is a smart move. Depending on your circumstances, you may have two options for keeping your coverage:

### What do I need to do to convert or port my coverage?

#### CONVERSION

Change your group term life coverage to an individual whole life policy, which builds cash value. You pay the premium at individual rates. The right to convert your policy is guaranteed by law under certain circumstances.

**Convert:**

Have your employer complete Section 1 of the life conversion form (rates included on the form).

Complete Section 2 of the conversion form yourself.

#### PORTABILITY

Take your group term life coverage with you and pay for it at group rates. This coverage does not build any cash value. This option is also called "porting" your coverage.

**Port:**

Have your employer complete Section 1 of the life/AD&D portability form (rates available through your employer).

Complete Section 2 of the life/AD&D portability form yourself.

| Can convert coverage | Can port coverage | When can an employee convert or port life insurance? This table shows the circumstances under which they are eligible to convert or port their coverage. |
|---|---|---|
| Yes | Yes | Retiring from the company |
| Yes | Yes | Employment has been terminated |
| Yes | Yes | Hours have been reduced so no longer qualify for coverage |
| Yes* | No*** | Leaving because of an illness or injury or because of hospital/home confinement |
| Yes** | No | Employer has canceled the group policy or Unum has made changes that make them ineligible for coverage |
| Yes | No | Child is aging out of dependent status (when a child reaches maximum age as outlined in the contract or up to the specific policy's age limitation for full-time student status) |
| Yes | No | Amounts that an employee or spouse loses due to age reduction |

#### NEXT STEPS

Submit the appropriate form **no later than 31 days** after your coverage ends to:
*Unum, Portability and Conversion Unit, 2211 Congress Street, Portland, ME 04122.*

Remember to designate a beneficiary and sign and date the election form.

**You have four ways to pay:** Monthly automatic payment or quarterly, semi-annually or annually by check / money order.

Communication decisions are provided directly to employees.

**Important:** Don't miss your chance to keep your life insurance. After your coverage ends, you have just 31 days to apply.
**Questions?** Please call 800-421-0344.



EN-1144063-2

| Coverage available to convert or port: | CONVERSION Life insurance only | PORTABILITY Life insurance and AD&D |
|---|---|---|

## Dependents' options

| | CONVERSION | PORTABILITY |
|---|---|---|
| When can dependents convert or port coverage? | • Dependents can convert their coverage if you are eligible to convert, or if you pass away while covered under the group plan.<br>• Dependents can convert even if you do not.<br>• Dependents can convert if they no longer meet the eligibility requirements under the plan. | • Dependents can port their coverage if you port.<br>• If you pass away, your spouse must port coverage in order to port children's coverage.<br>• Spouses can port coverage for themselves and their children if they are divorced from you. However, children's coverage can be ported under the employee's or spouse's coverage, but not both.<br>• Once children lose their dependent status (when they reach the maximum age as outlined in the contract or up to the specific policy's age limitation for full-time student status), their coverage ceases. |
| Can dependents be added after coverage is converted or ported? | No. Dependents who did not convert their coverage when you pass away can't be added or convert their coverage later. | If allowed under the policy, Dependents may be added up to the available coverage amounts with Evidence of Insurability. |

## Maximum coverage amounts

| | CONVERSION | PORTABILITY |
|---|---|---|
| What are the maximum coverage amounts for employees? | Maximum coverage amount is the amount for which you were insured under the group plan.<br>If you have been insured for at least 5 years and your employer has canceled the group policy, or Unum has made changes that make you ineligible for coverage, the maximum will be the lesser of: $10,000; or your coverage amount under the plan minus any other group coverage that your employer makes available within 31 days. | The maximum coverage amount is the lesser of: Your group maximum benefit; 5X your annual salary; or $750,000 from all Unum life and AD&D plans combined.<br>If your group policy offers a "retiree" class or coverage, you can port the difference between the group and retiree coverage amounts.<br>AD&D cannot exceed the ported life amount. |
| What are the maximum coverage amounts for dependents? | Same as for employees. | Spouse: The highest amount of life insurance available for your spouse under the plan; or 50% or 100% of the employee's ported coverage depending on the group contract; or $750,000 from all Unum group life and accidental death and dismemberment plans combined, whichever is less.<br>Child: The highest amount of life insurance available for your child under the plan; or 50% or 100% of the employee's amount (varies by contract); or $20,000, whichever is less (actual amount may differ based on plan design). AD&D cannot exceed the ported life amount. |

## Maximum coverage amounts

| | CONVERSION | PORTABILITY |
|---|---|---|
| Will my rates change? | Your rate will be different when you convert the policy from a group to an individual policy.<br>After that, you will pay the same premium for the life of the policy. | Your rate may change when you port the coverage. Also, because life premiums are based on age, your premiums will automatically increase in 5-year increments. For example, if you are 42 now, your premiums will increase when you are 45, then 50, and so on. |
| Will my coverage be reduced as I get older? | No. Your benefit will remain the same. | Yes. Employee and dependent coverage will reduce on an age-related schedule, according to the group plan. Note: You can convert the difference between the age-reduced coverage amount and the prior amount. Coverage may not be able to be ported after the age of 70 and ported coverage may terminate at age 75. Refer to the certificate of coverage to determine if these restrictions apply. |
| Can I increase my coverage? | No. Once you have converted your coverage, you cannot increase it. | If allowed under the policy, employees may increase their coverage up to the plan maximums with Evidence of Insurability. The employee may decrease their coverage as long as it remains within plan guidelines. |

* State variations apply.
** Available only if you have been insured under the plan for at least five years. You can convert to a policy with a maximum benefit of $10,000.
*** Portability may be available if the policy does not include the sickness and injury provision or the home/hospital confinement provision.
Refer to the certificate of coverage for more information.
The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. See the actual policy or your Unum representative for specific provisions and details of availability.
Underwritten by Unum Life Insurance Company of America, Portland, Maine
In New York, underwritten by First Unum Life Insurance Company, Garden City, NY. Individual Whole Life insurance will be underwritten by one of Unum Group's insuring affiliates.
For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al.

Better benefits at work.™

unum.com


EN-1144063-2 FOR EMPLOYEES (8-23)

## Important Information When Considering Portability Coverage

When your group term life insurance coverage ends, either because your employment has terminated or you no longer are eligible to participate in your employer's group life policy, you have two choices for continuing your life insurance coverage: Portability or Conversion. While there are a number of differences between portability and conversion, some key considerations are:

- **Portability** allows you and your dependents to continue (or "port") your Life and/or AD&D coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer's group life insurance policy. **Importantly, you cannot port coverage for anyone who has an injury or sickness which has a material effect on life expectancy.**
- **Conversion** allows you and your dependents to purchase individual life insurance policies (but not AD&D) at rates that may be higher than portability rates. The conversion policies you choose will not contain the exact same coverage you had under your employer's group life insurance policy. **Unlike portability, conversion is available even if you or your dependents have a sickness or injury which has a material effect on life expectancy.**

If you believe Portability is right for you, read the information below to determine whether you and your dependents are eligible to port your coverage.

**PORTABILITY COVERAGE IS NOT AVAILABLE FOR ANYONE WITH AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. This means individuals diagnosed with, or having received medical advice or sought treatment for, any of the following injuries or sicknesses in the past 10 years cannot elect this coverage:**

| | |
|---|---|
| • Acquired immune deficiency syndrome (AIDS)<br>• Amyotrophic lateral sclerosis (ALS)<br>• Cerebral palsy with cognitive impairment<br>• Chronic renal disease<br>• Chronic lung disease, including emphysema<br>• Cirrhosis of the liver<br>• Congestive heart failure<br>• Coronary artery disease, heart surgery, or transient ischemic attack (TIA)<br>• Cystic fibrosis<br>• Dementia, including Alzheimer's disease<br>• Diabetes other than gestational or diet controlled<br>• Drug or alcohol abuse<br>• Hepatitis B or C<br>• High blood pressure concurrently treated with three or more medications | • Leukemia, lymphoma or any cancer other than basal or squamous cell carcinoma of the skin<br>• Morbid obesity defined as a Body Mass Index (BMI) greater than 40<br><br>*Calculate a BMI using the Center for Disease Control's BMI Calculator online at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html or call us with height/weight information and we'll calculate it for you.*<br><br>• Muscular dystrophy<br>• Psychiatric hospitalization<br>• Quadriplegia<br>• Stroke<br>• Systemic lupus erythematosus or any other rheumatologic disease |

**If you are not sure whether anyone applying for this coverage has an injury or sickness in the list above,** then attach to this election form the name of the individual with the injury/sickness, his/her relationship to you, a description of the condition, and any current medications. Unum will review the information provided and let you know whether portable coverage is an option.

**Important:** When a life insurance claim is submitted to Unum on an individual who died within two years of the date that portability coverage became effective, Unum reviews medical records to determine whether the deceased individual was eligible for portability. If Unum determines the deceased individual wasn't eligible for portability due to an injury or sickness which had a material effect on life expectancy, the beneficiary will not receive the portability amount elected. Instead, the beneficiary will receive a significantly reduced benefit (or possibly no benefit at all). Please see the Portability section of your employer's group policy for an explanation of how the benefit may be reduced.

If after reading the information on this page you believe you and/or your dependents aren't eligible to elect portability coverage, remember that you and your dependents may qualify for conversion coverage. Contact your employer for the conversion application form and rates.

If you believe you and/or your dependents are eligible for portability, continue to the next page.

## Important Information

**What type of coverage can be ported?**

- **Basic Life** is insurance that your employer provided for you when you were in active employment.
- **Supplemental Life** is insurance elected by you for which you paid the premiums when you were in active employment.
- **AD&D** is Accidental Death & Dismemberment coverage and may not exceed Life coverage.

**What are your employer's responsibilities?**

- Fully complete Section 1 of this election form and provide it to the employee. Incomplete election forms may result in a denial of coverage.
- Provide the portability rate table to the employee.

**What are your responsibilities as the employee?**

- Complete Section 2 on this election form and the Beneficiary Designation Form. Incomplete forms may be denied.
- Portable coverage is available in amounts up to your current coverage amounts without evidence of insurability—but cannot exceed $750,000 across all Unum Life and AD&D coverages, the lesser of 5x salary or $750,000 or the maximum allowed under your plan across all Unum Life and AD&D coverages combined.
- If you wish to elect coverage in an amount other than your current coverage amount, provide the requested amounts. Coverage is subject to the minimum and maximum limits provided in the employer's policy. Contact your employer for a copy of the group life insurance policy.
- Please remember to (1) include your ACH form; (2) sign and date this election form; (3) designate a beneficiary; and (4) retain a copy of this entire form for your records.
- Mail completed forms to the address listed at the top of the election form.

**What should you know when completing your Beneficiary Designation Form?**

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).
- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).
- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a child's court-appointed financial guardian. The regulations governing minor beneficiaries vary by state.
- **Trust** – You may designate a valid trust as a beneficiary.
- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.
- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

**TERM LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE**
Submit to: Unum Life Insurance Company of America (Unum) Portability Unit
2211 Congress Street, Portland, ME 04122 • 1-800-421-0344 • Fax 207-575-2993

**EMPLOYER COMPLETES SECTION 1**

| | | | |
|---|---|---|---|
| Company Name: | Policy Number | Division | Class |
| Employee Name (Last, First, MI): | Policy Number | Division | Class |
| Date Coverage Ends (mm/dd/yyyy): | Insured on disability or sick leave when terminated? ☐ Yes* ☐ No | Reason for Loss of Coverage: ☐ Terminated Employment ☐ Retired ☐ Reduced Hours (must be working) ☐ Other, Explain | |
| Current Annual Earnings: | *If Yes, date premium paid to: | | |

**Fill in Current Coverage Amounts for Each Insured and Insurance Type**

| Insured Type | Basic Life | Supplemental Life | Basic AD&D | Supplemental AD&D |
|---|---|---|---|---|
| Employee | | | | |
| Spouse | | | | |
| Child | | | | |

| | |
|---|---|
| Plan Administrator Name: | Plan Administrator Signature: |
| Plan Administrator Telephone Number: | Plan Administrator Email: |

**EMPLOYEE COMPLETES SECTION 2**

| | | | |
|---|---|---|---|
| Insured Mailing Address (Street, PO Box, City, State, Zip): | | Home Telephone: Alternate Telephone: | |
| Insured Social Security Number: | Insured Date of Birth (mm/dd/yyyy): | Gender: ☐ Male ☐ Female | |
| Spouse Name: | Spouse Date of Birth (mm/dd/yyyy): | Spouse Social Security Number: | |
| Child Name: | Date of Birth: * | Child Name: | Date of Birth: * |
| Child Name: | Date of Birth: * | Child Name: | Date of Birth: * |

* Check the policy or your certificate. Dependent eligibility is subject to age, student and/or marriage status.

Have you used tobacco products in the past twelve months? ☐ Yes ☐ No

Has your spouse used tobacco products in the past twelve months? ☐ Yes ☐ No

**Fill in Requested Coverage Amounts for Each Insured and Insurance Type - coverages left blank will result in a coverage amount of $0. Coverage reduces according to your employer's group insurance policy.**

| Insured Type | Basic Life | Supplemental Life | Basic AD&D | Supplemental AD&D |
|---|---|---|---|---|
| Employee | | | | |
| Spouse | | | | |
| Child | | | | |

**ALL PREMIUMS TO BE PAID MONTHLY VIA AUTOMATIC PAYMENT. Please complete and send in the enclosed Authorization and Agreement for Automatic Payments form with your application.**

☐ I am opting out of monthly payments and want to pay:
☐ Quarterly (Every three months) ☐ Semi-Annually (Every six months) ☐ Annually (One time per year)

I understand and agree to the following:
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 being offered and is subject to satisfaction of the conditions provided therein.

Portable coverage will be effective the first of the month after your group coverage ends subject to your applying for portable coverage for yourself and your dependents within 31 days after the date your group coverage ends.

**HAVING READ AND UNDERSTOOD THE "IMPORTANT INFORMATION WHEN CONSIDERING PORTABILITY COVERAGE" SECTION ON PAGE 1 OF THIS FORM, I CERTIFY THAT NEITHER I NOR MY DEPENDENTS HAVE AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. I UNDERSTAND UNUM IS RELYING ON THIS CERTIFICATION AS A MATERIAL CONDITION TO ITS AGREEMENT TO PROVIDE COVERAGE.**

If Unum determines that an injury or sickness has a material effect on life expectancy, as of the date portable coverage was elected, benefits may be reduced to the amount of coverage available under the current policy's conversion privilege.

| Insured Signature: | Today's Date (mm/dd/yyyy): | Insured's Email Address |
|---|---|---|
| | | |

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.

AE-1213 (04/21)

**PORTABILITY BENEFICIARY DESIGNATION FORM**
2211 Congress Street
Portland Maine 04122
Phone: 1-800-421-0344
Fax: 207-575-2993

**Instructions:** Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper.

## PART 1: Information About You

Name (Last Name, Suffix, First Name, MI)

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Policy Number ☐☐☐☐☐☐ Division ☐

## PART 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 & Address | Telephone Number | Relationship | Social Security Number | Date of Birth | Percent |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Total Must Equal 100% |

## PART 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 & Address | Telephone Number | Relationship | Social Security Number | Date of Birth | Percent |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Total Must Equal 100% |

## PART 4: Signature

X

**Signature** **Date**



AE-1213 (04/21)

## HOW TO CALCULATE YOUR PORTABILITY PREMIUM PAYMENT

| **Calculate Your Premium Payment** | |
|---|---|
| 1. Find your rate on the rate table under appropriate tobacco use, if applicable. The rate is based on your age at the time your coverage terminates or is reduced.<br>**Note:** You will qualify for non-tobacco premium rates if you have not used any tobacco products within the last 12 months.<br>Your life insurance rates will continue to increase with age, every 5 years ( for example, at age 50, 55, 60 etc.). | Base Rate Per $1,000 of Coverage _____ |
| 2. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.<br>**Note:** You may be eligible to increase your coverage which would require Evidence of Insurability subject to maximums outlined in your former group insurance policy. | Amount of Coverage _____ |

| | | | |
|---|---|---|---|
| 3. a. | Base Rate Per thousand dollars of coverage: | Base Rate | _____ |
| b. | Number of thousand dollars you want: | # of $1,000 Units | x_____ |
| c. | Multiply a. by b.: | Base Rate X # of Units | _____ |
| d. | Mode you would like to pay<br>Monthly = 1<br>Quarterly = 3<br>Semi-annual = 6<br>Annual = 12 | Mode | x_____ |
| e. TOTAL c. and d. This is your premium | | *TOTAL | _____ |

*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding

**Sample Portability Premium Calculation:**

1. A 44 year old person decides to continue $25,000 of coverage
2. The person wishes to pay premiums annually
3. The monthly rate for a 44 year old is $.510 per $1,000 of coverage
4. Calculate premiums:

| | | |
|---|---|---|
| a. | Base rate per thousand dollars of coverage: | $.510 (sample rate) |
| b. | Number of thousand dollar units you wanted: | x 25 |
| c. | Multiply a. by b.: | $12.75 (Monthly) |
| d. | Multiply c. by 12 for annual | x 12 |
| e. | TOTAL. This is the sample premium amount. | $153.00 (Sample Annual Premium) |

**Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.**

**Unum Life Insurance Company of America**
**Authorization and Agreement for Automatic Payments**
**Drawn By and Payable To:**
**Unum Life Insurance Company of America (hereinafter referred to as "the Company")**
**2211 Congress Street, Portland, Maine 04122**
**1-800-421-0344 Fax number: 207-575-2993**
**email to: PortabilityConversion@unum.com**

**PLEASE PRINT**

| BL#/POLICY NUMBER | INSURED NAME | SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |
| | | |

☐ Please apply this to all my policies

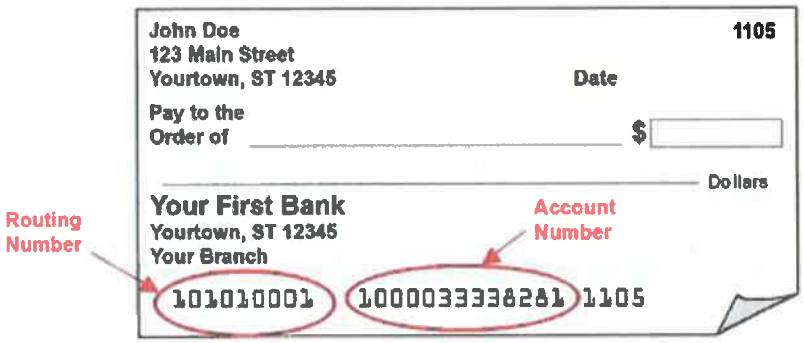
1. Purpose for submitting this authorization form:
   ☐ New Preauthorized payment plan ☐ Change in bank
   ☐ Addition of new policy to plan ☐ Change in account number

   Type of Account:
   ☐ Checking
   ☐ Savings

2. Current Address: _____
3. Name of Banking Institution: _____
4. Name on Bank Account: _____
5. Routing Number (9 digits): ___ ___ ___ ___ ___ ___ ___ ___ ___
6. Account Number: _____

Refer to the sample check for help locating the Routing Number and Account Number. Attach or scan a Voided Check (optional).

**Sample Check**




**APPLICANT INFORMATION FOR BANK:**

You are hereby authorized, as a convenience to me, to pay and charge to my account any check or electronic fund transfer drawn on this account on the first of the month by and payable to the order of the company(s) indicated above for itself (themselves), provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or transfer shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice and you have had a reasonable time to act on it. I agree that you shall be fully protected in honoring any such check or transfer.

I further agree that if any such check or transfer be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

| Signature of Depositor | Date |
|---|---|
| Please print name as signed above | |

**A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL**


CS-1157 (07/18)

# PORT RATES
# 103

## EMPLOYEE

| Non-Tobacco | | Tobacco | |
|---|---|---|---|
| Age | Monthly Rate Per $1,000 | Age | Monthly Rate Per $1,000 |
| 0-24 | $0.09 | 0-24 | $0.13 |
| 25-29 | $0.09 | 25-29 | $0.13 |
| 30-34 | $0.09 | 30-34 | $0.14 |
| 35-39 | $0.12 | 35-39 | $0.20 |
| 40-44 | $0.17 | 40-44 | $0.30 |
| 45-49 | $0.27 | 45-49 | $0.48 |
| 50-54 | $0.42 | 50-54 | $0.80 |
| 55-59 | $0.68 | 55-59 | $1.12 |
| 60-64 | $1.01 | 60-64 | $1.57 |
| 65-69 | $1.76 | 65-69 | $2.61 |
| 70-74 | $3.17 | 70-74 | $4.58 |
| 75-79 | $5.35 | 75-79 | $6.91 |
| 80-84 | $8.50 | 80-84 | $9.56 |
| 85-89 | $12.26 | 85-89 | $12.63 |
| 90- + | $24.58 | 90- + | $24.58 |

## SPOUSE

| Age | Monthly Rate Per $1,000 |
|---|---|
| 0-24 | $0.13 |
| 25-29 | $0.13 |
| 30-34 | $0.14 |
| 35-39 | $0.19 |
| 40-44 | $0.27 |
| 45-49 | $0.42 |
| 50-54 | $0.66 |
| 55-59 | $1.00 |
| 60-64 | $1.74 |
| 65-69 | $2.99 |
| 70-74 | $5.32 |
| 75-79 | $8.72 |
| 80-84 | $13.40 |
| 85-89 | $19.05 |
| 90- + | $37.83 |

Note: If your plan has AD&D, your AD&D rates will match the inforce AD&D rates. Portability rates for the entire block of individuals may change at any time in the event of poor experience or due to legislative or other mandated changes which affect the risk.

**CHILDREN:** $0.28 per $1,000 of coverage Monthly

**THIRD PARTY AUTHORIZATION**
**PORTABILITY PROTECTION PLAN**
**Unum Life Insurance Company of America**
**Unum Insurance Company**
**2211 Congress Street**
**Portland, ME 04122**
**Attention: Portability/Conversion Unit**
**Fax: 207-575-2993**

For toll-free assistance call: 1-800-421-0344

| POLICY OWNER NAME | BL# | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | BL# | | | | | | | |

| AUTHORIZED INDIVIDUAL(S) NAME | Relationship to the Policy Owner | PHONE NUMBER |
|---|---|---|
| | | |
| | | |

I authorize Unum Group, its subsidiaries and affiliates* and duly authorized representatives ("Unum") to disclose the following insurance plan, policy billing and beneficiary information to the person(s) or organization(s) listed above, for the purpose of assisting me with my insurance coverage:

- Information regarding my coverage, including policy provisions and riders;
- Information regarding premium calculation, invoicing and payments; and
- Name(s) of designated beneficiaries (if applicable).

This authorization does not alter any prior designation made under any law protecting against unintentional lapse of coverage.

This authorization does not allow the authorized individual(s) or organization(s) to make any changes to my coverage, policy, riders, beneficiary designations, or assignments under my policy.

This Authorization does not allow Unum to share claim or health information including, but not limited to, my medical condition, diagnosis, treatment, or pre-existing condition information; the names of my physicians and other medical providers; or benefit amounts paid to me or on my behalf.

Unum will rely on this authorization until I revoke it in writing.

Unum may provide information in writing, electronically, or by telephone (including voice mail messages).

**CERTIFICATION**

- **I understand that once information is disclosed to the named authorized Individuals or Organizations, it may no longer be protected by federal privacy regulations.**
- I am not required to sign this authorization and Unum may not condition payment of claims on whether I sign this authorization.
- I am entitled to receive a copy of this authorization.
- I may revoke this authorization in writing at any time, except to the extent that Unum has relied on the authorization prior to notice of revocation.

Policy Owner Signature  Date Signed

Print Name

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life Accident Insurance Company and Provident Life and Casualty Insurance Company.


CS-1220 (06/18)

**LIFE INSURANCE**
**NOTIFICATION OF CONVERSION PRIVILEGE**
Unum Life Insurance Company of America (Unum)

1. **Conversion rights** – When your group life insurance terminates or the amount of coverage you have is reduced, you can convert your coverage to an individual Whole Life Policy or you may purchase a Single Premium Convertible One-Year Term Life Policy. You may purchase either of these options without having to provide evidence of insurability.
2. **Start Conversion within 31 days** – Your life insurance coverage under your employer's group policy remains in effect for 31 days after the date of termination or reduction of coverage. You may apply for conversion any time within that period.

   If you do not apply within 31 days, the option to convert will no longer be available to you.

   **How to apply for Conversion**
   If you wish to convert your group life insurance coverage to an individual policy, complete the attached application and send it to:

   Unum
   Portability and Conversion Unit
   2211 Congress St.
   Portland, Maine 04122

3. **Amount of coverage you can buy** – When your group coverage terminates or reduces, you can apply for any amount of life insurance up to, but not exceeding the amount you had under your group plan.
4. **Cost of an individual policy** – The rates included in this package show the cost of an individual policy. If your rate is not listed, please call Unum at 1-800-421-0344.

**COMPLETING THE APPLICATION**

1. **Employer completes this section** – Employer must complete the top section of the application before giving to the employee.
2. **Employee completes this section** – Employee must complete this section in order to continue this coverage.
   a. **Print Insured's Name** – Enter full name, check male or female and enter date of birth.
   b. **Applicants / Dependent's Name (if other than insured)** – Enter the name of the person applying for insurance if it is other than the insured person. Check male or female and enter date of birth.
   c. **Insured's Address** – Enter full mailing address of the insured.
3. **What type of insurance are you electing?** You may elect Individual Whole Life or a Single Premium Convertible One-Year Term Life Policy. If you elect the Single Premium Convertible Policy, your Whole Life Insurance Policy will become effective after one year provided the premium due is received within the lifetime of the insured and within the Grace Period as provided in your Whole Life Policy.
4. **What is the amount of insurance you wish to convert** – Enter the exact amount of life insurance you wish to convert to an individual policy. Please note that you may not convert an amount in excess of the amount of coverage you held under the group policy.
5. **Check premium payment mode** – Check the box next to the mode of payment that you elect to pay your premiums.
6. **Do you wish to elect Automatic Premium Loan** – You are entitled to have any loan value on the policy automatically used to pay any premium which is unpaid on expiration of the 31 day grace period.
7. **Whom do you wish as beneficiary(ies) under the Individual Policy** – Enter the full name and relationship of your Primary and Contingent beneficiaries.
8. **Signatures –**

**Insured's Signature** – The person whose life is being covered for insurance must sign the application unless he/she is under 18 years of age.
**Applicant's Signature** – If the insured is under 18 years of age, the parent or guardian who will be paying the insurance premiums must sign here.
**Witness Signature** – Any person other than the insured must sign as a witness to the application.

**Special Instructions for Completing the Application**

- **A separate application must be completed for each applicant applying for coverage.**
- **Any changes made to your answers must be initialed and dated.**

**APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE TO AN INDIVIDUAL LIFE INSURANCE POLICY**
Unum Life Insurance Company of America

## 1. Employer Completes this Section

| Company Name | | Group Policy and Division Numbers | |
|---|---|---|---|
| Employee's Name (Last, First, MI) | | Social Security Number | Date of Birth |
| Dependent Name (if converting dependent coverage) | | Social Security Number | Date of Birth |
| Group life insurance benefits were: ☐ Terminated ☐ Reduced | Reason for Termination | Date of Termination or Reduction | Amount of Coverage Lost $ |
| Was the employee disabled on date of termination or reduction? ☐ Yes ☐ No<br>If yes, see (waiver of premium) Extension of Employee Life Insurance Provision of the group contract, if available under the group plan. | | Date of Disability (Date last worked) | |
| Has Employee submitted a claim for extension of group benefit? ☐ Yes ☐ No | | Was the group life coverage previously assigned? (collateral/absolute) ☐ Yes ☐ No | |
| Employer Signature | | Date | |

## 2. Employee Information

| A. Print Insured's Name (Last, First, Mid. Int.) | Sex ☐ M ☐ F | Date of Birth |
|---|---|---|
| B. Applicant's/Dependent's Name (if other than insured) | Sex ☐ M ☐ F | Date of Birth |

C. Insured's Address (No. & Street, City, State, Zip Code and Phone Number)

**3.** I elect the following life insurance:
☐ Whole Life Only ☐ Single Premium Convertible One-Year Term Life with automatic conversion to Whole Life
**Note:** The individual policy that you convert to will not contain waiver of premium or accidental death benefits.

**4.** What is the amount of insurance you wish to convert? $_____
**Note:** The amount may not exceed the amount shown in section 1.

**5.** Check premium payment mode
☐ Annually
☐ Semi-Annually
☐ Quarterly

**6.** Do you wish to elect automatic premium loan?
☐ Yes
☐ No

**7.** Whom do you wish as beneficiary(ies) of proceeds under the individual policy?
Primary: _____
If beneficiary(ies) named above not living, then pay:
Contingent: _____

I UNDERSTAND AND AGREE THAT: (1) The statements and answers in the above application are true, complete and correctly recorded to the best of my knowledge and belief. (2) Any policy issued on this application will be issued in accordance with the conversion privilege contained in the Group Policy. (3) The policy will become effective on the day following the last day of the conversion period prescribed under the Group Policy. (4) The beneficiary designation above has no effect on the beneficiary designation for any death benefits payable under the Group Policy. (5) If any death benefit paid under the Group Policy includes an amount representing the coverage shown in item 4 above, the individual policy will be void from the beginning. In this case, we, Unum Life Insurance Company of America, will refund to the beneficiary any premium paid. **See reverse side for fraud notices.**

| **8.** Insured's Signature | Date | Applicant's/Dependent's Signature | Date | Witness Signature (if other than insured) | Date |
|---|---|---|---|---|---|
| | | | | | |

## FRAUD NOTICE

**For Residents of California: For your protection California law requires the following to appear on this form:** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For Residents of Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**For Residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For Residents of Kansas:** Any person who knowingly and with intent to defraud presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of Kentucky, Ohio and Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For Residents of Minnesota:** Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

**For Residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**For Residents of New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**For Residents of Puerto Rico:** Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**For Residents of the District of Columbia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of All Other States:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

## Conversion Rates

| Age | Annual Rate 1-Year Term | Rates for Individual Whole Life Annual | Semiannual | Quarterly | Age | Annual Rate 1-Year Term | Rates for Individual Whole Life Annual | Semiannual | Quarterly |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 5.05 | 2.06 | 1.07 | 0.57 | 46 | 8.92 | 22.08 | 11.48 | 6.07 |
| 1 | 5.05 | 2.16 | 1.12 | 0.59 | 47 | 9.66 | 22.62 | 11.76 | 6.22 |
| 2 | 5.05 | 2.27 | 1.18 | 0.62 | 48 | 10.41 | 23.44 | 12.19 | 6.45 |
| 3 | 5.05 | 2.39 | 1.24 | 0.66 | 49 | 11.15 | 24.52 | 12.75 | 6.74 |
| 4 | 5.05 | 2.51 | 1.31 | 0.69 | 50 | 11.89 | 25.87 | 13.45 | 7.11 |
| 5 | 5.05 | 2.63 | 1.37 | 0.72 | 51 | 13.47 | 27.95 | 14.53 | 7.69 |
| 6 | 5.05 | 2.77 | 1.44 | 0.76 | 52 | 15.05 | 29.88 | 15.54 | 8.22 |
| 7 | 5.05 | 2.91 | 1.51 | 0.80 | 53 | 16.62 | 32.08 | 16.68 | 8.82 |
| 8 | 5.05 | 3.05 | 1.59 | 0.84 | 54 | 18.20 | 34.56 | 17.97 | 9.50 |
| 9 | 5.05 | 3.21 | 1.67 | 0.88 | 55 | 19.78 | 38.69 | 20.12 | 10.64 |
| 10 | 5.05 | 3.37 | 1.75 | 0.93 | 56 | 21.73 | 39.23 | 20.40 | 10.79 |
| 11 | 5.05 | 3.54 | 1.84 | 0.97 | 57 | 23.69 | 40.31 | 20.96 | 11.09 |
| 12 | 5.05 | 3.72 | 1.93 | 1.02 | 58 | 25.64 | 41.94 | 21.81 | 11.53 |
| 13 | 5.05 | 3.91 | 2.03 | 1.08 | 59 | 27.60 | 44.10 | 22.93 | 12.13 |
| 14 | 5.05 | 4.11 | 2.14 | 1.13 | 60 | 29.55 | 46.81 | 24.34 | 12.87 |
| 15 | 5.05 | 5.29 | 2.75 | 1.45 | 61 | 32.82 | 51.32 | 26.69 | 14.11 |
| 16 | 5.10 | 5.56 | 2.89 | 1.53 | 62 | 36.08 | 55.21 | 28.71 | 15.18 |
| 17 | 5.15 | 5.83 | 3.03 | 1.60 | 63 | 39.35 | 59.65 | 31.02 | 16.40 |
| 18 | 5.29 | 6.10 | 3.17 | 1.68 | 64 | 42.61 | 64.64 | 33.61 | 17.78 |
| 19 | 5.43 | 6.36 | 3.31 | 1.75 | 65 | 45.88 | 72.96 | 37.94 | 20.06 |
| 20 | 5.74 | 6.99 | 3.63 | 1.92 | 66 | 49.74 | 76.31 | 39.68 | 20.99 |
| 21 | 5.49 | 7.27 | 3.78 | 2.00 | 67 | 53.61 | 79.66 | 41.42 | 21.91 |
| 22 | 5.24 | 7.55 | 3.93 | 2.08 | 68 | 57.47 | 83.01 | 43.17 | 22.83 |
| 23 | 5.00 | 7.84 | 4.08 | 2.16 | 69 | 61.34 | 86.36 | 44.91 | 23.75 |
| 24 | 4.75 | 8.12 | 4.22 | 2.23 | 70 | 65.20 | 93.06 | 48.39 | 25.59 |
| 25 | 4.50 | 8.40 | 4.37 | 2.31 | 71 | 73.41 | 105.19 | 54.70 | 28.93 |
| 26 | 4.35 | 8.65 | 4.50 | 2.38 | 72 | 81.63 | 112.26 | 58.38 | 30.87 |
| 27 | 4.20 | 8.90 | 4.63 | 2.45 | 73 | 89.84 | 119.32 | 62.05 | 32.81 |
| 28 | 4.06 | 9.15 | 4.76 | 2.52 | 74 | 98.06 | 126.38 | 65.72 | 34.75 |
| 29 | 3.91 | 9.40 | 4.89 | 2.59 | 75 | 106.27 | 147.58 | 76.74 | 40.58 |
| 30 | 3.76 | 9.65 | 5.02 | 2.65 | 76 | 114.77 | 156.43 | 81.34 | 43.02 |
| 31 | 3.82 | 11.55 | 6.01 | 3.18 | 77 | 123.95 | 165.82 | 86.23 | 45.60 |
| 32 | 3.88 | 11.84 | 6.16 | 3.26 | 78 | 133.87 | 175.77 | 91.40 | 48.34 |
| 33 | 3.94 | 12.13 | 6.31 | 3.34 | 79 | 144.58 | 186.31 | 96.88 | 51.24 |
| 34 | 4.00 | 12.42 | 6.46 | 3.42 | 80 | 156.15 | 197.49 | 102.69 | 54.31 |
| 35 | 4.06 | 12.85 | 6.68 | 3.53 | 81 | 168.64 | 209.34 | 108.86 | 57.57 |
| 36 | 4.30 | 12.98 | 6.75 | 3.57 | 82 | 182.13 | 221.90 | 115.39 | 61.02 |
| 37 | 4.53 | 13.25 | 6.89 | 3.64 | 83 | 196.70 | 235.22 | 122.31 | 64.69 |
| 38 | 4.77 | 13.64 | 7.09 | 3.75 | 84 | 212.43 | 249.33 | 129.65 | 68.57 |
| 39 | 5.00 | 14.16 | 7.36 | 3.89 | 85 | 229.43 | 264.29 | 137.43 | 72.68 |
| 40 | 5.24 | 15.61 | 8.12 | 4.29 | 86 | 247.78 | 280.15 | 145.68 | 77.04 |
| 41 | 5.83 | 16.43 | 8.54 | 4.52 | 87 | 260.17 | 296.95 | 154.41 | 81.66 |
| 42 | 6.42 | 17.40 | 9.05 | 4.79 | 88 | 273.18 | 314.77 | 163.68 | 86.56 |
| 43 | 7.00 | 18.50 | 9.62 | 5.09 | 89 | 286.84 | 333.66 | 173.50 | 91.76 |
| 44 | 7.59 | 19.74 | 10.26 | 5.43 | 90 | 301.18 | 353.68 | 183.91 | 97.26 |
| 45 | 8.18 | 21.81 | 11.34 | 6.00 | | | | | |

**Policy Fee is as follows:**
**$90.00 per annual payment**
**$46.80 per semi annual payment**
**$24.75 per quarterly payment**

**Please note: Rates are per $1,000 of coverage**

AE-1066 (06/21)

## How to Calculate Your Premium Payment

| **Calculate Your Premium Payment** | **Check Your Elections Below** |
|---|---|
| 1. Determine if you want the whole life or the 1-Year Term coverage. The 1-Year Term will be renewed next year at your attained age to Whole Life coverage assuming premiums are paid in full. If you elect the 1-Year Term, you must submit an annual premium payment. Note that the 1-Year Term coverage is not available in all states. | Whole Life ☐ 1-Year Term ☐ |
| 2. If you have selected whole life, determine whether you want to pay your whole life premiums annually, semi-annually, or quarterly. | Annual ☐ Semi-Annual ☐ Quarterly ☐ |
| 3. Find your rate on the rate table. The rate is based on the type of coverage you want and your age at the time your conversion coverage begins, which is 31 days from the time your group coverage terminates or is reduced. | Base Rate per $1,000 of Coverage _____ |
| 4. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan. | Amount of Coverage _____ |

5. **Calculate Your Premiums**

| | | |
|---|---|---|
| a. Base rate per thousand dollars of coverage: | Base Rate | _____ |
| b. Number of thousand dollar units you want: | # of $1,000 Units | x _____ |
| c. Multiply a. by b.: | Base Rate X # of Units | _____ |
| d. If you selected whole life, add the policy fee: | Policy Fee | + _____ |
| No policy fee for 1-Year Term | | |
| Annual $90.00 per payment | | |
| Semi-annual $46.80 per payment | | |
| Quarterly $24.75 per payment | | |
| e. TOTAL c. and d. This is your premium. | * TOTAL | _____ |

* This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding.

**Example**

1. A 44 year old person decides to convert to a whole life policy
2. The person wants to convert $25,000 of coverage
3. The person wants to pay premiums semi-annually
4. The semi-annual rate for a 44 year old is $10.26 per $1,000 of insurance
5. Calculate premiums:

| | |
|---|---|
| a. Base rate per thousand dollars of coverage: | $10.26 |
| b. Number of thousand dollar units you want: | X 25 |
| c. Multiply a. by b.: | $256.50 |
| d. If you selected whole life, add the policy fee: | |
| No policy fee for 1-Year Term | $0.00 |
| Annual $90.00 per payment | - |
| Semi-annual $46.80 per payment | $46.80 |
| Quarterly $24.75 per payment | - |
| e. TOTAL c. and d. This is your premium. | $303.30 |

**Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.**

# Application for Portability of Critical Illness Insurance

**Underwritten by Life Insurance Company of North America, a Cigna Company**
(Herein called the Insurance Company)

**NEW YORK FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

For residents of the following states, please see the last page of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.***

**Please use this form to submit your request to continue coverage under the Portability Provision of the Policy. Please complete the form and don't forget to include your Social Security Number, your Birthdate, and to sign your name and enter today's date.**

Return completed form to: Cigna
PO Box 29230
Phoenix AZ 85038-9920

## EMPLOYER USE SECTION – TO BE COMPLETED BY THE EMPLOYER

***Please be sure to complete all items.***

Employer _____ Policy # _____

Employee Name _____ Class _____

Date Notice Completed _____ Date Notice Provided to Employee _____

Employee's Coverage Effective Date _____ Spouse or Domestic Partner's Coverage Effective Date _____

Child(ren)'s Coverage Effective Date _____ Type of Coverage: ☐ Basic ☐ Voluntary

Critical Illness Coverage in Force on Employee's Last Day Worked *(if no coverage in force, enter $0)*:

Employee _____ Spouse or Domestic Partner _____ Child(ren) _____

Employment Category ☐ Full-Time ☐ Part-Time

Date of Hire _____ Last Day Worked _____ Coverage Termination Date _____

Employment Termination Date _____

Reason to Initiate Portability: ☐ Change to another Class ☐ Inactive ☐ Leave of Absence ☐ Strike ☐ Termination ☐ End of Continuation Provision ☐ Layoff ☐ Military Service ☐ Retirement

Employer Signature _____ Date _____

**Note to Employer:** ***Be sure to check the group policy regarding portability limitations.***

## EMPLOYEE INFORMATION

First Name _____ Last Name _____

Social Security Number _____ Birthdate _____ Gender ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____

Have you smoked or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

## SPOUSE OR DOMESTIC PARTNER INFORMATION

First Name _____ Last Name _____

Social Security Number _____ Birthdate _____ Gender ☐ Male ☐ Female

Has your Spouse or Domestic Partner smoked or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

Do you wish to continue Critical Illness coverage for your Spouse or Domestic Partner? ☐ Yes ☐ No

**Note:** ***Coverage may be continued on your Spouse or Domestic Partner only if you had coverage for them while you were actively employed.***

**Please turn to other side to complete form. Be sure to make a copy for your records.**

874348 06/2016

Employee Name _____ Social Security Number _____

## CHILD(REN) INFORMATION

Do you wish to continue Critical Illness coverage for your dependent child(ren)? ☐ Yes ☐ No

How many children are you covering? _____

***Note: Coverage may be continued on your dependent child(ren) only if you had coverage for them while you were actively employed.***

## GENERAL INFORMATION

1. **Eligibility** – You must be covered under the policy for the required amount of time and cannot be above the maximum age to continue your coverage. If you do not meet these requirements you will not be eligible to continue your coverage. These limitations may be reviewed in your Certificate.
2. **Rates** – You will continue with group rates, but rates may be subject to change.
3. **Deadline** – You have 31 days from the date coverage ended to exercise the portability option. Mail or fax your completed form promptly.
4. **Effective Date** – Your ported insurance will become effective on the date your insurance would otherwise have terminated, if you have applied and agreed to pay required premiums within 31 days of the date you would otherwise have ceased to be eligible.
5. **Coverage Changes** – If you have any questions on how to make changes to this coverage, please contact our Customer Service Center at 1-800-754-3207 for assistance.
6. **Billing** – You will be billed on a quarterly basis; however, your initial bill may be for a shorter or longer period of time for billing cycle reasons. 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.

## SIGNATURE

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.).

**Please Sign Here**

Employee's Signature _____ Date _____

**Complete this form, sign and date, and return to: Cigna, P.O. Box 29230, Phoenix AZ 85038-9920 or by fax to 1-800-440-0856.**
**Do not return this form to your employer.**
**For questions, please contact our Service Center toll-free at 1-800-754-3207, Monday through Friday 8 a.m. to 8 p.m. Eastern Time .**



874348 06/2016

## IMPORTANT CLAIM NOTICE

***California Residents:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

***Colorado Residents:*** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

***District of Columbia Residents:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

***Florida Residents:*** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

***Kentucky Residents:*** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

***Maryland Residents:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***Minnesota Residents:*** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

***New Jersey:*** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

***Oregon Residents:*** 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, may have committed a fraudulent insurance act.

***Pennsylvania Residents:*** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

***Rhode Island Residents:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***Tennessee Residents:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

***Texas Residents:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

***Virginia Residents:*** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

# HOSPITAL CASH PORTABILITY FORM

CHUBB®

Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
Email: CWBPortabilityConversion@Chubb.com; Toll Free Number: 888-499-0425

**EMPLOYER COMPLETES SECTION 1**

| Company Name: | Policy Number | Division | Class |
|---|---|---|---|
| | | | |

Employee Name (Last, First, MI):

Date Coverage Ends (mm/dd/yyyy):

**Fill in Current Requested Coverage for Each Insured**

| Insured Type | Hospital |
|---|---|
| Employee | ☐ Plan 1 ☐ Plan 2 (if applicable) |
| Spouse | ☐ Yes ☐ No |
| Child | ☐ Yes ☐ No |

Plan Administrator Name:

Plan Administrator Signature:

Plan Administrator Telephone Number:

Plan Administrator Email:

**EMPLOYEE COMPLETES SECTION 2**

Mailing Address (Street, PO Box, City, State, Zip):

Home Telephone:

Alternate Telephone:

Social Security Number:

Date of Birth (mm/dd/yyyy):

Gender:
☐ Male ☐ Female

Spouse Name: ☐ Continue Coverage ☐ Drop Coverage

Spouse Date of Birth (mm/dd/yyyy):

Spouse Social Security Number:

Child Coverage ☐ Continue Coverage
☐ Drop Coverage

Per your policy, child eligibility is subject to age limits.

**Fill in Requested Coverage:**

| Insured Type | Hospital |
|---|---|
| Employee | ☐ Continue Coverage ☐ Reduce Coverage (Subject to Availability) |

**ALL PREMIUMS TO BE PAID MONTHLY VIA AUTOMATIC PAYMENT. Please complete and send in the enclosed Authorization and Agreement for Automatic Payments form with your application.**

I understand and agree to the following:
Any coverage chosen on this request form will only be issued in accordance with the portability provision contained in the Employer's Group Hospital Cash policy under which this coverage is being offered, and is subject to satisfaction of the conditions provided therein.

Once a request for portability has been received and approved, portable coverage will be effective the day after coverage would have otherwise ended under the Employer's policy, so long as your initial premium payment is received.

Signature:

Today's Date (mm/dd/yyyy):

Email Address:

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.

CHUBB®

# PORTABILITY BENEFICIARY DESIGNATION FORM

Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
Email: CWBPortabilityConversion@Chubb.com; Toll Free Number: 888-499-0425

**Instructions:** Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper.

## PART 1: Information About You

Name (Last Name, Suffix, First Name, MI)

Social Security Number

Policy Number

Division

## PART 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Accident 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 & Address | Telephone Number | Relationship | Social Security Number | Date of Birth | Percent |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Total Must Equal 100% |

## PART 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 & Address | Telephone Number | Relationship | Social Security Number | Date of Birth | Percent |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | Total Must Equal 100% |

## PART 4: Signature

**X**
**Signature**

**Date**

CHUBB®

# HOSPITAL CASH PORTABILITY FORM

Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
Email: CWBPortabilityConversion@Chubb.com; Toll Free Number: 888-499-0425

## Important Information When Considering Portability Coverage

When your Hospital Cash insurance coverage ends, either because your employment has terminated or you are no longer eligible to participate in your employer's hospital policy, you may be eligible to port your policy. Portability allows you to continue (or 'port') your coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer's hospital policy. Some key considerations are:

## Important facts to remember

- Portability is not available to employees who are no longer actively at work due to a disability, retirement, layoff or leave of absence.
- Portability allows you, your spouse or child(ren) to continue (or "port") Accident coverage at group rates.
- The ported coverage will be subject to the same provisions contained in your employer's Group Accident insurance policy.
- Employees may only request to continue their current coverage.
- Employees may not increase a benefit when porting coverage.
- Continued coverage may be canceled by Chubb if the Employee:
    - fails to pay required premium within the policy's grace period for payment;
    - is rehired and becomes eligible under the group policy;
    - retires, or
    - dies.

## What are the Employer's responsibilities?

- Fully complete Section 1 of the request form and provide to the participant. Incomplete request forms may result in a denial to continue coverage.
- Determine if terminating employee is eligible to apply for portability of Accident Insurance.
- Provide separate requests forms when portability is offered under more than one insurance policy.
- Provide premium rates and portability request forms to eligible terminating employees.

## What are the Employee's responsibilities?

- Fully Complete Section 2. Sign and date the request form. Incomplete request forms may result in a denial to continue coverage.
- Select the amount of coverage to be continued.
- Send the request form to the mailing or email address listed at the top of page 1, within the deadline to request portability.
- Please remember to sign and date this request form with today's date; and retain a copy of this for your records.

# Individual Automatic Premium Collection Agreement and Authorization

CHUBB®

Employee Name: _____

Email: _____ Phone: _____

I, the individual who is signing below, hereby authorize Combined Insurance Company of America ("Combined"), a Chubb company, to initiate electronic debit entries or to effect a change by any other commercially accepted method, to my checking account (as shown below) in the financial institution named below (hereinafter called Depository). I specifically authorize Depository to debit my account on a monthly basis to pay premiums for the insurance for which I have applied today. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination. I understand that such notification from me must be given with sufficient time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it. I also authorize Combined to change the amount of my debit: (1) to correct clerical errors in the initial premium calculation for the selected coverage(s) and (2) to reflect changes in premium resulting from Combined's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my debit are to be made only at the direction of Combined and such change(s) does not require any other subsequent or additional authorization by me.

I understand that if premiums are not paid within the grace period under the subject policy(ies) or certificate(s), as in the event withdrawals are dishonored, the policy(ies) or certificate(s) will terminate. However, certain life insurance policies may contain non-forfeiture provisions and/or automatic premium loan provisions, which may extend coverage for a period of time. The specific provisions of each policy will govern.

Depositor Name: _____
(Please Print)

Depositor Signature: _____ _____
(Signature must be the same as on file at the bank/financial institution.) (Date)

Preferred draft date of each month: ☐

Draft Amount $ ☐

| TYPE OF COVERAGE | POLICY/CERTIFICATE NUMBER |
|---|---|
| | |
| | |

**Complete the information below or attach a voided check.**

**Name of Bank**

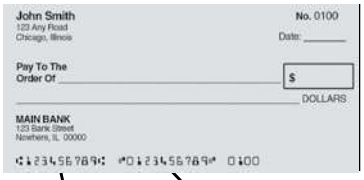
**City & State of Bank**

**Routing (ABA) Number** (9 digits)

**Account Number**

**Account Type**

☒ Checking




**9 DIGIT ROUTING NUMBER**

**ACCOUNT NUMBER**

Combined Insurance Company of America • P.O. Box 6704 • Scranton, PA 18505-0704 • Ph. 1-888- 499-4025

TEXASLIFE INSURANCE COMPANY

# REQUEST FOR CASH SURRENDER

Contract Number: _____

Insured Name: _____

**INSTRUCTIONS:** Use this form to request a full surrender and termination of your life insurance contract with the Company. The owner of this contract assigns the contract to the Company and acknowledges that any loan on this contract is a first lien and shall be deducted from the Cash Value. The owner declares that there are no proceedings of insolvency or bankruptcy against him or her and that no other person, firm or corporation has any interest in said contract except the owner. To process your request the Company must receive BOTH pages of this form in our office and the form must be satisfactorily completed. The Company will accept the form by fax, mail, or email. See **'How To Submit This Form'** on Page 2.

## ABOUT THE CONTRACT OWNER:

**If Individual:**

Owner Name _____ Owner Social Security Number _____

Phone Number _____ E-Mail Address _____

**If Trust or Business Entity:**

Print Full Name of Trust/Business Entity _____ Date Trust Executed (mm/dd/yyyy) _____

Tax ID No. of Trust/Business Entity _____ Phone Number _____ E-Mail Address _____

Contact Person - Full Name _____ Title _____

## Full surrender, termination and payment

I request a full surrender and termination of the life insurance contract listed above and request payment of the proceeds.

**Please provide the address where your check should be mailed:**

Street Address _____ City _____ State _____ Zip _____

Should we use this address for all future correspondence with you? ☐ Yes ☐ No

## Lost Contract Statement:

If the original contract is not enclosed with this request, the owner of this contract certifies the above contract has been lost or destroyed and agrees to return the original contract to the Company, without claim, should it be found.

## About Income Tax Withholding

Under current federal income tax law, we are required to withhold 10% of the taxable portion of the cash surrender value and pay it to the IRS unless you tell us in writing not to withhold tax. Some states also require us to withhold state income tax if we withhold federal tax.

You are responsible for paying income tax on the taxable portion of your payment even if we do not withhold taxes. In making your decision about withholding taxes, you should consider that penalties under the estimated income tax rules may apply if your withholding and estimated income tax payments are not sufficient.

**Please Check One:** ☐ **Withhold** ☐ **Do Not Withhold**

*(This choice is void if we do not have your Social Security Number or Tax ID Number)*

## CERTIFICATION:

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, and;
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and;

*(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*

3. I am a U.S. Citizen or other U.S. person, and;
4. I am not subject to Foreign Account Tax Compliance Act (FATCA) reporting because I am a U.S. person and the account is located within the United States.

*(If you are not a U.S. Citizen or other U.S. person, for tax purposes, please cross out the last two certifications and complete appropriate IRS documentation.)*

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

## Florida Residents - Review the statement below and check if applicable:

☐ Check this box if your insurance agent recommended (advised) you to surrender your life insurance contract and the surrender proceeds will NOT be used to fund or purchase another life insurance contract or annuity contract.

- The state of Florida requires that we first provide you with important disclosure information.
- We are unable to send your surrender proceeds via EFT or wire. We will promptly send you a check.
- Provide an E-Mail address or fax number in the space provided below so we can send the important disclosure information to you.

E-Mail Address _____ Fax Number _____

**SIGNATURE(S):** The request for cash surrender must be dated current. The signature of the contract owner must be written exactly as the name appears in the contract or any subsequent endorsements to the contract.

**If Individual:**

Signature of Contract Owner _____ Date _____

**If Trust or Business Entity:**

Authorized Signature _____ Date _____

Please Print Full Name _____ Title _____

## HOW TO SUBMIT THIS FORM:

**MAIL:**
Texas Life
P. O. Box 830
Waco, TX 76703-0830

**FAX:**
254-745-6393

**E-MAIL:**
customerservice@texaslife.com

TEXASLIFE INSURANCE COMPANY

# Automatic Bank Draft Form

*A convenient payment option for you...*

## Three Easy Steps:

1. Read and complete each item on the Automatic Bank Draft Form.
2. Include either a voided check or deposit slip or provide bank information below.
3. Include any payments due.

Please enter all Texas Life Insurance Company contract numbers you want drafted with this authorization: _____

_____

Texas Life will begin drafting your account for the current or any outstanding premiums due immediately upon receipt of this form. The premium(s) will be drafted on the contract due date(s).

Bank Name: _____ Please check appropriate box:

Account Holder Name: _____ ☐ Checking

Routing #: _____ ☐ Savings

Account #: _____ **OR** include a voided check or deposit slip

Contact information:

Cell Number: ( _____ ) _____ Work Number: ( _____ ) _____

Drafts are submitted to the bank on the day your form is received, if past due. Drafts should clear your account within 2 - 3 days. If your draft date falls on a weekend or holiday, it will leave our office on the next business day.

*As a convenience to me, I hereby request and authorize you to pay and charge to my account drafts drawn on my account by and payable to the Texas Life Insurance Company, Waco, Texas provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such draft shall be the same as if it were a draft drawn on you and signed personally by me. The payment of premium under this plan may be discontinued by the Company or the undersigned. You shall be under no obligation to determine the correctness of the amount of any draft drawn under this authority. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. For the purpose of this form, a facsimile copy of my signature shall be as valid as an original. (Fax (254)745-6393)*

**Signature of Bank Account Holder** **Date**



061016 R06/20

**Since 1901** | 900 WASHINGTON AVE | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830 | 800-283-9233 | 254-752-6521 | www.texaslife.com