



P.O. Box 1650  
Little Rock, Arkansas 72203

Please Print Using Dark Ink

## Application for Portability of Group Term Life

Office Use Only	
Policy #	
Effective Date	
Group #	

### SECTION A - APPLICANT INFORMATION

Name (First, MI, Last)			Social Security No.		
Home Address		City	State	Zip	County
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Home Phone
Date of Termination of Employment	Reason for termination: <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> _____			Are you a fulltime member of the armed forces of any country? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or your spouse used tobacco products in the past year? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse (if applying for coverage) <input type="checkbox"/> Yes <input type="checkbox"/> No					

### SECTION B - EMPLOYER INFORMATION (This section is to be completed by the Employer)

1. Employer Name	Group Policy Number
2. Did the Insured Employee terminate his employment due to disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Applicant's Employment Terminated
Did the Insured Employee terminate his employment due to retirement? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### SECTION C - PLAN INFORMATION

1. Current Amount of Term Life on Employee: \$ _____	
2. Current Amount of Term Life on Spouse: \$ _____	Continue Spouse's Term Life? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Premium Mode:	<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually

### SECTION D - SPOUSE INFORMATION (Complete only if applying for Portability of Spouse's Group Life Coverage)

Name (First, MI, Last)	Social Security No.	Date of Birth	Sex
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### SECTION E - BENEFICIARY This will revoke any existing beneficiary designations you may have under these benefits.

#### PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at applicant's death):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

**Total must equal 100% =**

#### CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

**Total must equal 100% =**

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded. Further, my signature below acknowledges that I have received a copy of this application. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary.

**Warning** - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

Signed at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ on \_\_\_\_\_ Month Day Year X \_\_\_\_\_ Signature of Applicant

EMPLOYER'S STATEMENT: I represent the above information is true, complete, and correctly recorded. X \_\_\_\_\_ Employer's Signature

### SECTION F - DECLINATION

I have been informed of my option to continue my group term life coverage. The Portability provision has been explained to me, and I have been given the opportunity to continue this coverage. I understand my option and decline such coverage.

\_\_\_\_\_  
Signature of Terminating Employee

\_\_\_\_\_  
Signature of Witness



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## Voluntary Group Term Life Portability Premium Calculation

An employee terminating employment may continue coverage up to the amount of the Voluntary Group Term Life in effect at the time of termination. If an employee continues coverage, the employee's spouse may also continue coverage. Children may not continue coverage under the "portability" provision but may be eligible to convert coverage to a Whole Life policy.

**Eligibility:** To be eligible to continue coverage, the applicant must be under age 80 or 65 if retired and may not be disabled. Portability is not available upon policy cancellation.

**Application:** Within 31 days of the date of termination from the group, the employer and employee should complete an "Application for Continuation of Group Life," form GRP-PORT-APP (5-09), and send it to US Able Life.

***The first premium must accompany the application. You must submit the application and premium payment within 31 days from the date of termination from the group.***

**Premium:** Premiums will be billed directly to the employee and may be billed annually, semi-annually or quarterly. Monthly billed or "bank withdrawal" is not available.

### Unismoker Rates for Employees and Spouses Per \$ 10,000 Unit

Ages	Annual	Semi-Annual	Quarterly
0-29	\$ 11.04	\$ 5.52	\$ 2.76
30-34	16.56	8.28	4.14
35-39	22.08	11.04	5.52
40-44	36.00	18.00	9.00
45-49	58.08	29.04	14.52
50-54	93.84	46.92	23.46
55-59	160.08	80.04	40.02
60-64	229.20	114.60	57.30
65-69	369.84	184.92	92.46
70-74	607.20	303.60	151.80
75+	1,010.10	505.05	252.53

#### Important Note:

Coverage reduces 50% of the pre-age 65 amount at age 65 and terminates at age 80, or age 65 if portability was due to retirement. Premiums increase on the following anniversary after reaching a new age-band rate.

#### Example

Employee age 45 and spouse age 43, neither are smokers, each wish to continue their coverage. The employee has \$50,000 and the spouse has \$20,000. They want to be billed semi-annually.

Employee	\$29.04 x 5 units =	\$145.20
Spouse	\$18.00 x 2 units =	<u>36.00</u>
Total semi-annual premium due		\$181.20

#### Premium Worksheet

	Table Rate	x	per \$10,000 unit		Premium
Employee		x		=	
Spouse		x		=	

For assistance or questions, please call US Able Life's Customer Care at 800-370-5856.