PORTABILITY OF VOLUNTARY TERM LIFE INSURANCE
(Employee)

Life Insurance Company of North America

Please print (preferably in black ink).

CIGNA Group Insurance
Life · Accident · Disability

EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER

Employer_____ Policy # _____

Name of Employee_____ Class _____

Voluntary Coverage Amount Eligible to Port: _____

Coverage Termination Date: _____ *Month/Day/Year*

Employment Termination Date: _____ *Month/Day/Year*

Reason for Termination of Group Insurance:

☐ Termination of Employment ☐ Cancellation of Group Contract ☐ Reduction in Benefit ☐ Other _____

☐ Change to Another Class ☐ Retirement ☐ Disability

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. The Owner may be other than the employee.***

****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_____

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

1. If you wish to continue your voluntary coverage, please check one:

☐ Continue amount of coverage currently in force or ☐ Decrease the coverage amount to _____ (Units of $1,000)

2. ☐ Check here if you want to increase your coverage. See item #5 in General Information.

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

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

☐ Conversion Application Date: _____ *Month/Day/Year*

☐ Waiver of Premium Application Date: _____ *Month/Day/Year*

☐ Accelerated Benefit/Terminal Illness Benefit Application Date: _____ *Month/Day/Year*

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	*Percentage*	*Social Security #*	*Date of Birth* Month/Day/Year	*Relationship*

Employee's Signature_____ Date _____ *Month/Day/Year*

Please Sign Here

LM-618483b (08/06)

Employee Name _____ Social Security #_____

Complete this section only if the 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.

_____ _____

Owner Name Tax I.D./Social Security Number

Street Address _____ City_____ State_____ Zip_____

☛ Owner's Signature_____ Date _____

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

GENERAL INFORMATION

1. **Rates —** Please note that rates for ported 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.
2. **Deadline —** You have 31 days from the Coverage Termination Date to exercise the portability option.
3. **Effective Date —** The effective date of your ported coverage will be the first day of the month following the Coverage Termination Date.
4. **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.
5. **Coverage Increases —** The benefit allows you to apply at any time for an increase in the amount of insurance you have in force. 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, and an Evidence of Insurability Form will be mailed to you.
6. **Coverage Terminations and Reductions —** Any age-related reductions in insurance continue to apply. 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, 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