



LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE

Unum Life Insurance Company of America (Unum)
Portability Unit
2211 Congress Street, Portland, ME 04122
1-800-421-0344

You may be eligible to continue your Life coverage. To apply, you must complete this form and send it to Unum with your initial premium payment within 31 days after your group insurance coverage ends. If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage.

(Please print in ink)

TO BE COMPLETED BY THE EMPLOYER

Company Name:	Group Policy Number/Division Number:
Insured on disability/sick leave when terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Coverage Ended (mm/dd/yyyy):
Reason for Loss of Coverage:	Current Annual Earnings:

Policyholder Signature	Date
Policyholder Telephone	Policyholder Email

In addition, please complete the current Group Life fields in the section below.

TO BE COMPLETED BY THE APPLICANT

Insured Name (last, first, initial)		Home Telephone #:	
Insured Mailing Address (Street, PO Box, City, State, Zip)		Work Telephone #:	
Social Security Number	Date of Birth (mm/dd/yyyy)	Have you used tobacco products in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

Select a premium payment option below. Please obtain your portability premium rates from your plan administrator and mail your initial premium payment, along with this election form, to the address shown above. **Make your check or money order payable to Unum.**

Select a premium payment option: Quarterly (monthly premium x3) Semi-Annually (monthly premium x6) Annual (monthly premium x12)

Please complete the information below. You may keep the same level of coverage or decrease coverage. You may also increase coverage or add dependents (if policyholder's plan has dependent coverage) subject to medical evidence of insurability. Note: For specific plan maximums, plan minimums, rounding rules and reduction formulas refer to your group certificate booklet.

	Yourself	Spouse	Child
Current Group Life Amount:	_____	_____	_____
Requested Portability Amount:	_____	_____	_____
Spouse Name:	_____	Spouse date of birth: _____	_____
		Spouse Social Security No.: _____	_____
Name of Beneficiary:	_____	Relationship to you: _____	_____

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 under which this coverage is offered and is subject to satisfaction of the conditions provided therein.
- Portability coverage will become effective the day after your group coverage terminates subject to Unum receiving a completed election form and the first premium within 31 days from the date your group coverage terminates.

Note: If you have any questions concerning your or your dependent's eligibility for portability coverage, please contact us at 1-800-421-0344.

If no dependent coverage is available under your group plan then any reference to "dependent" coverage is not applicable.

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