USAble Life

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 ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Home Phone	
Date of Termination of Employment	Reason for termination: ☐ Disabled ☐ Retired ☐ _____		Are you a fulltime member of the armed forces of any country? ☐ Yes ☐ No	

Have you or your spouse used tobacco products in the past year?
Employee ☐ Yes ☐ No Spouse (if applying for coverage) ☐ Yes ☐ 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? ☐ Yes ☐ No Did the Insured Employee terminate his employment due to retirement? ☐ Yes ☐ No	Date Applicant's Employment Terminated

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? ☐ Yes ☐ No
3. Current Amount of Term Life on Children $_____ Continue Children's Term Life? ☐ Yes ☐ No
4. Premium Mode: ☐ Quarterly ☐ Semi-Annually ☐ 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

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%	=0

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%	=0

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)