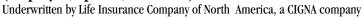
## **Portability of Voluntary Term Life Insurance**

(Employee, Spouse, Child/ren)







Please print (preferably in black ink).							
EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER Employer		Policy #					
Name of Employee	Class (required)						
Voluntary Coverage Amount that may be continued: Employee	Sn	ouse	Child				
· · · · · <u>-</u>							
Coverage Effective Date of Amount that may be continued:							
Last Day Worked: Coverage Termination Date: Month/Day/Year	Month /Day/Year	Employment Termina	tion Date:				
Reason for loss of Group Insurance: (not all reasons may qualify for por	rtability) Check only o	one.					
☐ Termination of Employment ☐ Cancellation of C	Group Contract	☐ Change to	Another Class				
☐ Reduction in Benefit ☐ Retirement	□ Disability	□ Other					
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. If ownership of coverage has been assigned, the Owner may be other than the employee or dependent.  ** NOTE: THIS FORM IS TO BE COMPLETED BY THE OWNER OF THIS COVERAGE**							
		OWNER OF THIS C	UVERAUE**				
Please print (preferably in black ink).	oyee Information						
		Stato	7in				
		State	Zip				
Gender Male Female	0 110 1		pud L.				
Day Phone Evening Phone	Social Security		Birthdate Month/Day/Year				
If you wish to continue your coverage, please check the app		ch type of coverage list	ed:				
☐ Increase your coverage. See item #5 in General Information							
<ul><li>2. Have you smoked or used any form of tobacco in the last 1.</li><li>3. Have you applied for: (Check all that apply.)</li></ul>		☐ Yes ☐ No					
☐ Conversion to an individual policy	Application Date:						
	_	Month/Day/Year					
☐ Waiver of Premium	Application Date:	Month/Day/Year	_				
☐ Accelerated Benefit/Terminal Illness Benefit	Application Date:	Monui/Day/Tear					
Accelerated benefit reminial limess benefit	Application Date.	Month/Day/Year	<u> </u>				
Spo	use Information						
Spouse's Name	Social Secur	itv#	Birthdate				
			Month/Day/Year				
<ul> <li>If you wish to continue voluntary coverage for your spouse</li> <li>☐ Continue amount of coverage currently in force</li> <li>☐ Decrease the coverage amount to</li> </ul>		-					
Ingresses enough coverage. See item 45 in Cover-11. Seems		f \$1,000)					
<ul> <li>☐ Increase spouse coverage. See item #5 in General Information</li> <li>2. Have you smoked or used any form of tobacco in the last 1:</li> </ul>		☐ Yes ☐ No					
3. Has your spouse applied for: (Check all that apply.)							
☐ Conversion to an individual policy	Application Date:						
D Academated Dec. Com	Annilia ette i Dir	Month/Day/Year					
☐ Accelerated Benefit/Terminal Illness Benefit	Application Date:	Month/Day/Year					
Child/ren Information							
Do you wish to continue coverage for your dependent child/ren		☐ Yes	□ No				

			,					
Beneficiary Information								
You must specify a beneficiary(ies) be distribution for each and the total must equal using the format below.	y completing the section belo	ow. When specifying multiple be						
Beneficiary (Employee Coverage)	Percentage	Social Security #	Date of Birth Month/Day/Year	Relationship				
Beneficiary (Spouse Coverage)	Percentage	Social Security #	Date of Birth Month/Day/Year	Relationship				
Beneficiary (Children Coverage)	Percentage	Social Security #	Date of Birth	Relationship				
Please sign here Emplo		Date Month/Day/Year						
				мония виу теш				
<b>Complete this Owner</b> – The Owner is the person who has the designated, the Employee shall be the Owner. A than yourself as the owner, an assignment form	e right to assign, surrender, a All correspondence and prem		ained in the contract. If no					
Owner Name		Tax I.D./Social Security Number						
Street Address								
City		State	Zip Code					

Social Security #

Date

Month/Day/Year

**Employee Name** 

Please sign here

Owner's Signature

## **General Information**

(Must be signed by Owner if other than employee.)

- 1. **Eligibility** Age limitations may exist which will limit your eligibility to continue coverage. These limitations may be reviewed in your certificate. If you do not meet the age requirements to continue your coverage, you can convert this coverage to any individual permanent policy then offered by the company.
- 2. **Rates** Please note that rates for continued 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.
- 3. **Deadline** You have 31 days from the Coverage Termination Date to exercise the portability option. If you were not notified of this right at least 15 days prior to the end of the 31-day period, you will have 15 days from the date notice is given to apply for continued insurance. In no event will this period be extended more than an additional 60 days.
- 4. **Effective Date** The effective date of your continued coverage will be the first day of the month following the Coverage Termination Date.
- 5. **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.
- 6. **Coverage Increases** The benefit allows you to apply at any time for an increase in the amount of insurance you have in force. For yourself or your family and/or apply for spouse or family coverage at any time. 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 for yourself or your spouse and an Evidence of Insurability Form will be mailed to you.
- 7. **Coverage Terminations and Reductions** Any age-related reductions in insurance continue to apply. You will need to contact NEBCO at the address shown below when a child is no longer eligible for coverage (refer to your certificate for additional information). 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 for yourself, your spouse and/or children, 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.

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