

# GROUP TERM LIFE PORTABILITY APPLICATION - EMPLOYEE

## ReliaStar Life Insurance Company

2N - New Business, 20 Washington Avenue South, Minneapolis, MN 55401

Phone: 800-955-7736; Fax: 612-342-7626

**IMPORTANT NOTE:** The Employer and Employee must complete all pertinent information on the following pages.

**MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.**

Return the completed form to the address shown above.

## EMPLOYER / ADMINISTRATOR

Read the certificate to determine eligibility for portability. Complete and sign Page 1 of this Portability Application form. Send this form to the Employee to complete the remaining pages. Include copies of beneficiary designations and assignments.

Employer or Group Name Rollins, Inc.

Group Policy Number 707392 Account Number 001

Hire Date \_\_\_\_\_ Annual Salary at Termination \$ \_\_\_\_\_

Employee Name \_\_\_\_\_ Employee Birth Date \_\_\_\_\_

Date Last Worked \_\_\_\_\_ Coverage Termination Date \_\_\_\_\_

## CURRENT COVERAGE INFORMATION

Employee Basic Life Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Employee Basic AD&D Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Employee Supplemental Life Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Employee Supplemental AD&D Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Spouse Supplemental Life Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Spouse Supplemental AD&D Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Children's Supplemental Life Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Children's Supplemental AD&D Insurance \$ \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

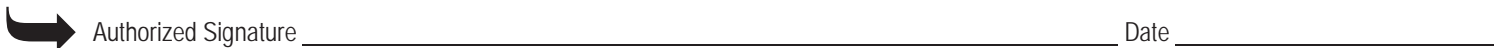
## EMPLOYER COMMENTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EMPLOYER ACKNOWLEDGEMENT

I certify that all above information is true and correct according to the records of the employer.

This form will be:  Handed  Mailed  Emailed to the employee on the following date \_\_\_\_\_

 Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Email \_\_\_\_\_ Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Employee Name \_\_\_\_\_

Group Policy Number 707392 Account Number 001

## EMPLOYEE INFORMATION

*Return the completed form to the address shown on Page 1. The insurer must receive this completed form within 60 days of the Coverage Termination Date. MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.*

Employee Name \_\_\_\_\_ Employee Birth Date \_\_\_\_\_

Employee Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Employee Phone (\_\_\_\_\_) \_\_\_\_\_ Employee SSN \_\_\_\_\_

## PORTABILITY INFORMATION

*The maximum amount allowed for portability is shown in the Portability Rider. Read the Portability Rider carefully to determine which coverage(s) are eligible for portability. You may only elect to port coverage that was in effect on the coverage termination date as shown on Page 1 of this Application. You will not be able to elect or increase ported coverage in the future.*

*Any life insurance amount that is not eligible for portability, or exceeds the maximum, may be converted to an individual policy. If you do not want to apply for portability and only want to receive information about conversion, you may skip the "Portability Elections" and "Evidence of Insurability" sections on this form.*

*Please contact the employer for copies of the certificate and riders describing coverage.*

## PORTABILITY ELECTIONS FOR EMPLOYEE COVERAGE

Employee Life Insurance I Elect to Port (Select one):  100%  75%  50%  25%  10%

Will not exceed the lesser of \$750,000 or 5 times Basic Yearly Earnings

Employee AD&D Insurance I Choose to (Select one):  Elect Coverage  Waive Coverage

If elected, percentage will be the same as Employee Life.

Employee Life must also be ported.

Will not exceed Employee Life amount ported.

## PORTABILITY ELECTIONS FOR SPOUSE COVERAGE

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

You must port Employee coverage in order to elect portability of Spouse coverage.

Spouse Name \_\_\_\_\_ Spouse Birth Date \_\_\_\_\_

Spouse Life Insurance I Choose to (Select one):  Elect Coverage  Waive Coverage

If elected, percentage will be the same as Employee Life.

Will not exceed total Employee Life amount ported.

Maximum = \$750,000

Spouse AD&D Insurance I Choose to (Select one):  Elect Coverage  Waive Coverage

If elected, percentage will be the same as Employee Life.

Spouse Life must also be ported.

Will not exceed total Spouse Life amount ported.

Will not exceed total Employee AD&D amount ported.

Employee Name \_\_\_\_\_

Group Policy Number 707392 Account Number 001

**PORTABILITY ELECTIONS FOR CHILDREN COVERAGE** (*Applies ONLY to currently Insured Children of the Employee as defined by the Children's Life Insurance Rider. Include additional pages if space is required for more Children.*)

The use of "child" or "children" in this form means a person insured as a child under the Children's Life Insurance Rider.

You must port Employee coverage in order to elect portability of Children's coverage.

Child Name \_\_\_\_\_ Child Birth Date \_\_\_\_\_

Child Name \_\_\_\_\_ Child Birth Date \_\_\_\_\_

Child Name \_\_\_\_\_ Child Birth Date \_\_\_\_\_

Child Name \_\_\_\_\_ Child Birth Date \_\_\_\_\_

**Children's Life Insurance**

I Choose to (*Select one*):  Elect Coverage  Waive Coverage

If elected, percentage will be the same as Employee Life.

Will not exceed total Employee Life amount ported.

Maximum = \$25,000

**Children's AD&D Insurance**

I Choose to (*Select one*):  Elect Coverage  Waive Coverage

If elected, percentage will be the same as Employee Life.

Children's Life must also be ported.

Will not exceed total Children's Life amount ported.

Will not exceed total Employee AD&D amount ported.

Employee Name \_\_\_\_\_

Group Policy Number 707392 Account Number 001

### EVIDENCE OF INSURABILITY FOR PREFERRED RATES

Portability is available at the standard rates shown on the attached sheet. If you want to apply for the preferred rates for you or your spouse, then you and your spouse must complete the questions below. If any questions are unanswered, the standard rates will apply.

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

Answer the following questions:

- 1. Are you terminating active employment due to an inability to perform the regular duties of your occupation? Employee:  Yes  No
- 2. In the last 5 years have you received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? Employee:  Yes  No  
Spouse:  Yes  No
- 3. In the last 5 years have you been diagnosed, treated, or been given medical advice by a member of the medical profession for: any disorder or disease of the heart or blood vessels (excluding controlled high blood pressure); any kidney disease; any neurological disease or disorder; any liver disease; chronic lung disease (excluding asthma); cancer (excluding non-melanoma skin cancer); stroke; diabetes; rheumatoid arthritis; lupus; Crohn's disease; or ulcerative colitis? Employee:  Yes  No  
Spouse:  Yes  No
- 4. In the last 10 years have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Employee:  Yes  No  
Spouse:  Yes  No

### CONVERSION INFORMATION


If you want to receive life insurance conversion information because: (1) you do not want portability, or (2) your elected ported life amount(s) would be less than 100% of the terminating life coverage amount(s), then please check this box:

Send Conversion Information

### ACKNOWLEDGEMENT *(Return the completed form to the address shown on Page 1.)*

- I have read this form and all statements and answers that pertain to me.
- All statements and answers as they pertain to me are true and complete to the best of my knowledge and belief.
- I understand that the statements and answers will be used by the insurer to determine insurability.
- I have received ReliaStar Life Insurance Company's Consumer Privacy Notice and Insurance Information Practices Notice.


**Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.**

 Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

City and State \_\_\_\_\_

 Spouse Signature <sup>1</sup> \_\_\_\_\_ Date \_\_\_\_\_

City and State \_\_\_\_\_

 Owner Signature <sup>2</sup> \_\_\_\_\_ Date \_\_\_\_\_

City and State \_\_\_\_\_

<sup>1</sup> Spouse Signature is required if Evidence of Insurability is completed above.

<sup>2</sup> Owner Signature is required only if the Owner is NOT the Employee.