



EQUITABLE

Group Employee Benefits Portability of Accident/Critical Illness Insurance (Employee, Spouse and Child/ren)

Regular/Express Mail:
Equitable Financial Life Insurance of America*
8501 IMB Dr. Ste 150-B
Charlotte NC, 28262
For assistance call (866) 274-9887

Employer use section: to be completed by the employer

Name of Employer: _____ Policy #: _____

Name of Employee: _____ Class: _____

Critical illness coverage amount eligible to port: Employee \$ _____ Spouse \$ _____ Child \$ _____

Accident coverage Eligible to Port: Employee Spouse Child(ren)

Reason for termination of group insurance:

- Termination of employment Disability Other: _____
- Cancellation of group contract Retirement

Date notice provided: _____ Coverage termination date: _____ Employment termination date: _____
Month/Day/Year Month/Day/Year 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 or dependent.

1. Employee information

Home address: _____

City _____ State _____ Zip _____

Daytime phone: _____ Evening phone: _____ SS #: _____ Birthday: _____
Month/Day/Year

If you wish to continue your supplemental/voluntary coverage, please make election(s) below:

For critical illness, port these amounts:

Employee _____ Spouse _____ Child(ren) _____

For accident, select coverage to be ported:

Employee _____ Spouse _____ Child(ren) _____

4. 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 (Employee Coverage)	Percentage	Social Security #	Date of birth <i>Month/Day/Year</i>	Relationship

Beneficiary (Spouse coverage)	Percentage	Social Security #	Date of birth <i>Month/Day/Year</i>	Relationship

Beneficiary (Children coverage)	Percentage	Social Security #	Date of birth <i>Month/Day/Year</i>	Relationship

5. Signature

Employee Signature: _____ Date: _____
Month/Day/Year

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 ported certificate. All correspondence and premium notices will be mailed to the owner and/or provided to the owner electronically as applicable.

Name of owner: _____ Tax I.D./Social Security #: _____

Street address: _____

City _____ State _____ Zip _____

Owner's Signature: _____ Date: _____
(Must be signed by Owner if other than employee) Month/Day/Year

6. General information

1. **Rates** – Please note that rates are subject to change. If you would like an estimated premium before applying for coverage, please call (866) 274-9887.
2. **Deadline** – You have 31 days from Coverage Termination Date to exercise the portability option.
3. **Billing** – Please provide a 3-month premium payment with the submission of this form. After your application is processed, you will be billed on a monthly basis. After the initial bill, you will receive your bill approximately 15 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly. Make all check payments payable to: **Equitable Financial Life Insurance Company of America** or **EFLOA**.
4. **Coverage terminations and reductions** – Any age-related reductions in insurance continue to apply. You will need to contact us at the address shown on the first page 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 Equitable. Please contact Equitable at the address shown on the first page of this form and we will provide you with the appropriate forms. At any time that you wish to cancel coverage for yourself, your spouse, and/or children, please call Equitable for instructions.
5. Complete this form, sign and date, and return to **Equitable Employee Benefits Group** at the address shown on page 1. For questions, please call Equitable at (866) 274- 9887.

All group insurance products are issued either by Equitable Financial or Equitable America, which have sole responsibility for their insurance and claims-paying obligations. Some products are not available in all states.

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