Group Employee Benefits

Portability of Basic, Supplemental and Voluntary Term Life Insurance
(Employee, Spouse and Child/ren)

Regular Mail:
Equitable
P.O. Box 733463
Dallas, TX
75373-3463

Express Mail:
JPMorgan Chase (TX1-0029)
Lockbox 733463 - Equitable
Financial Life Insurance
Company of America
Employee Benefits
14800 Frye Road, 2nd Floor
Fort Worth, TX 76155

EQUITABLE

Equitable Financial Life Insurance Company of America
For Assistance Call (866) 274-9887

EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER

Name of Employer: _____ Policy #: _____

Name of Employee: _____ Class: _____

Basic coverage Amount Eligible to Port (if applicable) Employee _____ Spouse _____ Child _____

Supplemental/Voluntary Coverage Amount Eligible to Port: Employee Spouse Child

Employment Termination Date _____
Month/Day/Year

Reason for Termination of Group Insurance:

☐ Termination of Employment ☐ Disability ☐ Other: _____

☐ Cancellation of Group Contract ☐ Retirement

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. The Owner may be other than the employee or dependent.*

1. Employee Information

Home Address: _____

City _____ State _____ Zip _____

Day Phone: _____ Evening Phone: _____ Social Security #: _____ Birthdate: _____
Month/Day/Year

Employee Email: _____

1. If you wish to continue your supplemental/voluntary coverage, please make election below:

☐ Continue amount of supplemental/voluntary coverage currently in force

2. Have you applied for: (Check all that apply)

☐ Conversion Application Date: _____
Month/Day/Year

☐ Accelerated Death Benefit Application Date: _____
Month/Day/Year

2. Spouse Information

Spouse Name: _____ Social Security #: _____ *Month/Day/Year*

1. If you wish to continue voluntary coverage for your spouse, please make election below:

☐ Continue amount of coverage currently in force

2. Has your spouse applied for: (Check all that apply)

☐ Conversion Application Date: _____
Month/Day/Year

☐ Accelerated Benefit/Terminal Illness Benefit Application Date: _____
Month/Day/Year

3. Child(ren) Information

Do you wish to continue your children coverage? ☐ **Yes** ☐ **No**

Please note, you cannot port child coverage unless the child meets the age and dependency requirements as defined in the group policy.

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 Name, Address and Phone # (Employee Coverage)	**Percentage**	**Social Security #**	**Date of Birth** ***Month/Day/Year***	**Relationship**

Beneficiary Name, Address and Phone # (Spouse Coverage)	**Percentage**	**Social Security #**	**Date of Birth** ***Month/Day/Year***	**Relationship**

Beneficiary Name, Address and Phone # (Children Coverage)	**Percentage**	**Social Security #**	**Date of Birth** ***Month/Day/Year***	**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 contract. If no other owner is designated, the Employee shall be the owner. 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 the date in which you are no longer part of an Eligible Class as defined in your certificate 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:
   Employers Headquartered in Non-NY States: **Equitable Financial Life Insurance Company of America or Equitable America**
4. **COVERAGE TERMINATIONS AND REDUCTIONS –** Any age-related reductions in insurance continue to apply. You will need to contact 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 EBCustomerservice@equitable.com or (866) 274-9887 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 **Employee Benefits Group** at the address shown on page 1, with a check or money order. For questions, please call Equitable at (866) 274-9887.
6. If you (the employee) return to work with your current employer, you must notify us immediately as your portability must be discontinued.

State Fraud Warnings

New York Fraud Warning:
"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

NY STATE RESIDENTS READ AND SIGN ONLY: I have read and understood the New York State Fraud Warning.

Signature:_____ _____
Employee's Signature **Current Date (mm/dd/yyyy)**

Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to civil and criminal penalties, including fines and confinement in prison.
Alaska and New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided under state law.
Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
California: For your protection, California law requires the following statement to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
Delaware, Florida, Idaho, Indiana, and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines or a denial of insurance benefits.
Kentucky and Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oregon and All Other States: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.
Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum two (2) years.