Group Employee Benefits

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

Regular: Equitable
PO Box 733464
Dallas, TX 75373-3464
Express Mail: Equitable
8501 IBM Dr Ste-150 B
Charlotte, NC 28262

EQUITABLE

Equitable Financial Life Insurance Company
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 app):Employee _____ Spouse _____ Child _____

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

Coverage Termination Date: _____ Employment Termination Date _____
Month/Day/Year *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

1. If you wish to continue your basic and/or supplemental/voluntary coverage, please select the applicable coverage option:

☐ Continue amount of basic employer-paid coverage currently in force if available to Port
☐ Continue amount of supplemental/voluntary coverage currently in force

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

☐ Conversion on this coverage Application Date: _____
Month/Day/Year

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

2. Spouse Information

Spouse Name: _____ Social Security #: _____ Birthdate: _____ *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 on this coverage 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 (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** ***Month/Day/Year***	**Relationship**

5. Signature

Employee's 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 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 or Equitable Financial Life Insurance Company of America.**
4. **COVERAGE TERMINATIONS AND REDUCTIONS –** Any age-related reductions in insurance continue to apply. You will need to contact Equitable 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.