Guardian®

Basic and/or Voluntary Group Term Life Insurance Election of Portability Coverage

Send this form to National Conversion Department PO Box 8070, Appleton WI 54912-8070
Fax number 920-749-6219 Secure E-mail: national conversions@glic.com

Planholder Name (Company Name)			Group Plan No.
Employee's Name (Last, First, MI)	Soc. Sec. No.	Birth Date	Sex ☐M ☐F
Employee's Home Address (Street, City, State, Zip)			
Home Telephone Number	Work Telephone Number	Email address (if applicable)	
Date Employment Terminated	Reason Employment Terminated		
Have You Applied or Will You Apply for the Extended Life Benefit under Your Employer's Plan?			

Please complete the following information for all dependents to be covered:

	Social Security Number	Sex	Birth Date	F/T Student
Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		☐M ☐F		
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -		☐M ☐F		☐Yes ☐No
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -		☐M ☐F		☐Yes ☐No
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -		☐M ☐F		☐Yes ☐No
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -		☐M ☐F		☐Yes ☐No

The following individuals are eligible to port the Life Insurance: the Employee ; the Employee and his/her Spouse; or the Employee and all eligible dependents. Also, in the event of the Employee's death, a surviving Spouse under age 70 may port the coverage for him/herself and all eligible dependent children.

Please indicate whose coverage will be ported:

☐ Employee Only
☐ Employee and Spouse
☐ Employee and All Eligible Dependents
☐ Surviving Spouse
☐ Surviving Spouse and Child(ren)

The amount that is eligible to be ported is a dollar amount equal to:

Option A - The full amount of the inforce Group Term Life Insurance; or
Option B - 50% of that amount (provided the ported amount is not less than $25,000 on the Employee $2,500 on the Spouse and $1,000 on the child(ren).

Please indicate whether you elect Option A or Option B.

☐ Option A ☐ Option B

Please indicate your beneficiary designation:

Name of Beneficiary: _____ Relationship _____

Address: _____ Phone Number: ( ) _____

Social Security Number:_____ Birth Date: _____

The enclosed Premium Notice outlines the monthly premium rates for this coverage.

Coverage is reduced by 35% at age 65. Coverage terminates at age 70.

Within 31 days of the date the Group Plan coverage ends due to your termination of employment, or the date your dependent's coverage ends as a result of your death, you or your surviving spouse must submit: (a) this completed form and (b) the premium payment. For ported insurance to remain in force all subsequent premium payments must be received within 31 days of the applicable premium due date. If premium payments are not received in a timely fashion, coverage will automatically terminate at the end of the 31 day period and all unpaid premiums will remain due from you or your surviving dependents for the period this coverage was inforce.

Signature: _____ Date: _____