

Send this form to National Conversion Depart Fax number 920-749-6219 Secure E-mail: nat				8070				
Planholder Name (Company Name)					Group Plan No.	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 ad			Email address (if applica	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 fo	r all depend	lents to be	covered:					
Spouse (First, MI, Last Name)		Social S	Security Number	Sex	Birth Date	F/T Student		
Address/City/State/Zip:								
Phone: () -								
Child/Dependent 1:						□ Yes □ No		
Address/City/State/Zip:								
Phone: () -								
Child/Dependent 2:						□ Yes □ No		
Address/City/State/Zip:								
Phone: () -								
Child/Dependent 3:						□ Yes □ No		
Address/City/State/Zip:								
Phone: () -								
Child/Dependent 4:						□ Yes □ No		
Address/City/State/Zip:								
Phone: () -								

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 do Option A - The full amount of the inforce Grou	p Term Life Insurance; or		
Option B - 50% of that amount (provided the p Spouse and \$1,000 on the child() on the Employee \$2,5	500 on the
Please indicate whether you elect Option A or C	Dption 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 mo	onthly 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: _____