CLEAR FORM

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Application for Portability of Basic and/or Voluntary Term Life Insurance (Former Spouse or Domestic Partner and Child/ren)

Underwritten by Life Insurance Company of North America
(Herein called the Insurance Company)

EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER/ADMINISTRATOR

Please print (preferably in black ink).

Employer/Policyholder Name: Trilliant Networks, Inc. Group Policy Number: SGM0607751

Name of Employee: _____ Class Number: _____

Reason for loss of Spouse or Domestic Partner: ***(not all reasons may qualify for portability)*** **Check All that apply.**

☐ Legal Separation/Divorce ☐ Death of Employee ☐ Other: _____

Coverage End Date: _____
(Month/Day/Year)

Reminders:

1) **If coverage terminates due to group policy cancellation, portability is not an option.**
2) **If coverage has already been reduced because of age, report both the original amount and the reduced amount as instructed below.**
3) **Life insurance portability may not be available on all of your terminating life insurance benefits (see your Certificate for details).**

Basic Life Coverage Amounts Eligible for Portability:

Premium paid through date for Basic Life Coverage _____
(Month/Day/Year)

Spouse or Domestic Partner Coverage Amount $ _____ **Group Coverage Effective Date:** _____
(Month/Day/Year)

Has Spouse or Domestic Partner coverage already been reduced because of age? ☐ Yes ☐ No *If Yes, complete the next line.*

Coverage amount (before any age reductions) $ _____ Coverage amount (after last age reduction) $ _____

Child Coverage Amount $ _____ **Group Coverage Effective Date:** _____
(Month/Day/Year)

Voluntary Life Coverage Amount Eligible for Portability:

Premium paid through date for Voluntary Life Coverage: _____
(Month/Day/Year)

Spouse or Domestic Partner Coverage Amount $ _____ **Group Coverage Effective Date:** _____
(Month/Day/Year)

Has Spouse or Domestic Partner coverage already been reduced because of age? ☐ Yes ☐ No *If Yes, complete the next line.*

Coverage amount (before any age reductions) $ _____ Coverage amount (after last age reduction) $ _____

Child Coverage Amount $ _____ **Group Coverage Effective Date:** _____
(Month/Day/Year)

Verification provided by:

_____ _____ **Date of Notice:** _____
Employer/Policyholder Signature *Title* *(Month/Day/Year)*

Telephone Number: _____ E-Mail Address: _____

Notes to Employer/Policyholder: *Be sure to check the group policy for* ***portability limitations*** *(i.e. age limitations).*

If any ***voluntary life coverage*** *was elected, please include enrollment history (forms and screen prints) for the coverage elected.*

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Spouse or Domestic Partner: _____ Social Security Number: _____

IMPORTANT:

- **If you had to submit medical evidence of good health for any part of the life insurance amount, please provide a copy of the approval letter, and/or any other related documentation that you received regarding the decision rendered.**

SECTION A *Please print (preferably in black ink).*

SPOUSE OR DOMESTIC PARTNER INFORMATION

Spouse's or Domestic Partner's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Birth date: _____ (Month/Day/Year) Social Security Number: _____

Day Phone: _____ Evening Phone: _____

1. If you wish to continue coverage, please check the appropriate box for each type of coverage listed:

Basic Coverage	Voluntary Coverage
☐ Continue amount of coverage currently in force	☐ Continue amount of coverage currently in force
☐ Decrease the coverage amount to $ _____ (Units of $1,000)	☐ Decrease the coverage amount to $ _____ (Units of $1,000)
☐ *Increase your coverage to $ _____ (Units of $1,000)	☐ *Increase your coverage to $ _____ (Units of $1,000)

**See "Coverage Increases" under the General Information section of this form.*

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

☐ Conversion to an individual policy Application Date: _____ (Month/Day/Year)

☐ Have you received or applied for Accelerated Death Benefit (ADB) Application Date: _____ (Month/Day/Year)

3. If applying for coverage because of Legal Separation or Divorce from the Employee, please provide the following:

a. Date of Legal Separation or Divorce: _____
b. Attach a copy of the Divorce Decree or Legal Separation Agreement.

4. If applying for coverage due to a death of the Employee, please provide the following:

a. Date of Death: _____
b. Attach a copy of the Death Certificate.

Note: *The portability death benefit amount will be reduced by the amount of coverage paid under the ADB Claim (Example Terminal Illness), however, the portability premiums may be required to be paid on the full amount of coverage in place prior to the reduction.*

CHILD/REN INFORMATION

Note: If you are applying to continue coverage for a Dependent Child or Children, you must complete the information below. Please note, you cannot continue child coverage unless each child meets the age and dependency requirements as defined in the group policy.

Do you wish to continue coverage for your dependent child(ren)? **Voluntary Coverage** ☐ **Yes** ☐ **No**
Basic Coverage ☐ **Yes** ☐ **No**

Dependent Child's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Birth date: _____ (Month/Day/Year) Social Security Number: _____

Phone Number: _____

Dependent Child's Name (First): _____ (Last): _____ (Middle Initial): _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Birth date: _____ (Month/Day/Year) Social Security Number: _____

Phone Number: _____

If you have additional children, attach, sign and date a separate sheet of paper using the format above.

Spouse or Domestic Partner: _____ Social Security Number: _____

BENEFICIARY INFORMATION

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Beneficiary Name (Spouse or Domestic Partner Coverage)	Percentage Total: 100%	Social Security Number	Date of Birth *(Month/Day/Year)*	Relationship
	%			
	%			
Beneficiary Name (Children Coverage)	**Percentage Total: 100%**	**Social Security Number**	**Date of Birth *(Month/Day/Year)***	**Relationship**
	%			
	%			

If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the above format including the appropriate policy number, the date, and your signature.

SECTION B

Read the Agreements and Authorization section that follows. Sign and date the form in the spaces provided.

* * * AGREEMENTS AND AUTHORIZATION * * *

To the best of my knowledge and belief all written, telephonic and electronic information I gave is true and complete.
The conditions for the requested Insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions.

Please sign and date here

If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).

Spouse or Domestic Partner's Signature: _____ Date: _____ *(Month/Day/Year)*

Caution: *Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.*

Spouse or Domestic Partner: _____ Social Security Number: _____

GENERAL INFORMATION

1. **Eligibility -** Age limitations may exist which will limit your eligibility to continue your coverage. These limitations may be reviewed in the originally issued Certificate. If you do not meet the age requirements to continue your coverage, you can convert this coverage to an individual whole life policy then offered by the Insurance Company.

2. **Rates -** Please note that rates under the Portability Option may be higher than those you paid previously, and they are subject to change. If you would like an estimated premium before applying for coverage, please call 1-800-423-1282.

3. **Deadline -** You will not have less than 31 days from the coverage end date to exercise the Portability Option. If you do not elect to continue insurance within the timeframe indicated in the Certificate of Insurance, you may not elect this coverage at a later date.

4. **Effective Date -** The effective date of your continued coverage will be the first day of the month following the Coverage End Date as reflected in the Employer Use section of this application or in the letter notifying you of your portability and conversion options, if applicable.

5. **Billing -** You will be billed on a quarterly basis. After the initial bill, you will receive your bill approximately 30 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly.

6. **Coverage Increases -** You may be able to increase your coverage in accordance with the terms of the group policy. If coverage increases are allowed under your plan (see the Certificate for details), you must provide satisfactory evidence of good health, and be approved by the Insurance Company. Please indicate in *"Section A"* of the application if you want to increase your coverage; a medical questionnaire form will be mailed to you.

7. **Coverage Decreases -** If you voluntarily elect to decrease your coverage, dependent coverage may also be required to be reduced at the same time if the policy contains this type of limitation (see the Certificate for details).

8. **Coverage Reductions -** Any age-related reductions in insurance may continue to apply. The Conversion Privilege related to any partial loss of coverage remains subject to the terms of the group policy (see the Certificate for details).

9. **Coverage Terminations -** Coverage will end as provided in the Portability Option of the group policy. Age-related termination of coverage may apply. When your coverage under the group policy ceases (for reasons other than non-payment of premium), you may be able to convert this coverage within the specified timeframe to an individual whole life policy then offered by the Insurance Company (see the Certificate for details).

Mail your completed and signed form to:

AmWINS Group Benefits LLC
P.O. Box 152501
Irving, TX 75015-2501

For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.

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