ABACUS SERIES

Distributed by
The Abacus Group LLC

Underwritten by
Union Security Insurance Company
Kansas City, MO

Election of Portability Coverage
Instructions & Application

ELIGIBILITY – Complete the attached application if you meet the following criteria:

If your coverage includes a Portability provision, you may continue your disability coverage for up to 12 months if your employment ends.

To be eligible to continue coverage, you must meet the following requirements on the date your employment ends:

1. you have been covered under this plan for at least 12 consecutive months before your employment ends;
2. you are not disabled as defined by this group disability plan;
3. you are not on a leave of absence;
4. you are not retired;
5. you are not covered under any other group disability plan; and
6. you are not absent due to a labor strike.

You must apply in writing within 31 days after the date your employment ends.

DESCRIPTION OF COVERAGE

- SHORT TERM DISABILITY: The insurance continued is the insurance in effect on the date your employment ends, including the benefit, the elimination period, the maximum period of payment and the amount of your earnings.
- LONG TERM DISABILITY: The insurance continued is 50% of the benefit level in force on the date your employment ended. In the event you become disabled, your monthly earnings will be based on your earnings in effect on the date your employment ended. The elimination period will be based on the elimination period of this plan and you may receive benefits for the lesser of 12 months or the maximum period of payment of this plan if you continued to be disabled according to the terms of the plan.

WHEN COVERAGE ENDS

Insurance continued under this provision ends automatically on the earliest of:

1. the last day of the period for which you made any required premium payments;
2. the date you become a full-time member of the armed forces of any country;
3. the date you retire;
4. the end of the 12 months during which your insurance is continued;
5. the date the plan terminates or the group policy terminates;
6. the date you become covered under another disability plan;
7. the date you were absent due to a labor strike; or
8. the end of 6 months after the effective date of Portability during which your insurance was continued and you are not employed.

Your Employer's plan may contain additional limitations concerning the amount of time coverage may be continued under the Portability provision. Refer to your certificate of coverage for details.

***INSTRUCTIONS*:** To continue your disability coverage, you must do the following:

Mail the original of completed application to: **Administrative Services**
300 Southborough Dr. Ste. 200
South Portland, ME 04106-6914

- or fax to AS at **1-877-820-5311**
- Keep a copy for your records
- Upon approval, you will receive a bill from AS. Monthly bills will be mailed to your home mailing address.

If you have any questions when completing this form, please call Toll-Free 1-(800) 877-2701.

ABACUS - ELECTION OF PORTABILITY COVERAGE

APPLICATION TO CONTINUE DISABILITY INCOME INSURANCE

☐ **Group Short-Term Disability Income Coverage**
☐ **Group Long-Term Disability Income Coverage**

To be completed by the Employee - Please type or print all information

1. Name of Insured_____ Last name First name Middle Initial		2. Gender ☐ Male ☐ Female
3. Social Security Number: - -	4. Daytime phone number ( ) -	5. Date of Birth / /
6. Mailing Address Street City State Zip Code		
7. Application is being made according to the Portability provision of Group Policy No./Participation No. _____ issued to: _____ (Legal Name of Employer)	8. Reason for requesting Portability coverage: My employment terminated on _____/_____/_____ Month Day Year Reason for terminating employment: ☐ Self-Initiated ☐ Retirement ☐ Labor Strike ☐ Lay Off ☐ Leave of Absence ☐ Other (explain)_____	
9. Are you disabled from a sickness or injury? ☐ Yes ☐ No	10. Annual Salary: (During the 12 months just prior to the date of this application - for this employer only) $ _____	

11. Are you covered for any other Disability Income Insurance other than item #7?
☐ Yes ☐ No If yes, please provide name of insurer _____
and policy type: ☐ Individual ☐ Group ☐ STD ☐ LTD
You are not eligible for the Portability Coverage if you have other group disability insurance.

FRAUD NOTICES

Unless specific state language is provided below, the following general fraud notice applies: *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 subjects such person to criminal and civil penalties.*

AR & LA Residents: *Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

CA Residents: *For your protection, California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.*

CO Residents: *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 policy holder or claim for purpose of defrauding or attempting to defraud the policy holder 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.*

DC Residents: *WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

FL Residents: *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.*

KS, MD, OR & VA Residents: *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 may be guilty of insurance fraud.*

NJ Residents: *Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.*

NY Residents: *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 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.*

The statements set forth above are true to the best of my knowledge and belief, and may be relied upon by Union Security Insurance Company in considering this application. Further, my signature below acknowledges that I have made a copy of my statements as they appear on this application.

Signature of Applicant_____ Date_____