

# Voluntary Life To Age 65 Portability Employee Application

(#980,066)

## FRAUD STATEMENTS

Please read the following before completing the attached form.

**If you live in the states of Arkansas, Louisiana or Rhode Island, the following statement applies to you:** Any person who knowingly presents a false or fraudulent claim for payment of a 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.

**If you live in the state of California, the following statement applies to you:** 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.

**If you live in the state of Colorado, the following statement applies to you:** 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

**If you live in the District of Columbia, the following statement applies to you:** 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.

**If you live in the state of Florida, the following statement applies to you:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**If you live in the state of Kentucky, the following statement applies to you:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**If you live in the state of Maryland, the following statement applies to you:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**If you live in the state of New Hampshire, the following statement applies to you:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**If you live in the state of New Jersey, the following statement applies to you:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**If you live in the state of Oregon, the following statement applies to you:** 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.

**If you live in the state of Virginia, the following statement applies to you:** 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 have violated state law.

**If you live in a state other than mentioned above, the following statement applies to you:** 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.

***To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the pages.***

Union Security Insurance Company

# Voluntary Life To Age 65 Portability Employee Application

(#980,066 Life Insurance only; no AD&D)

*This form must be fully completed including employer signature line, for accurate and timely processing.*

## A. Employee information

Name \_\_\_\_\_  
LAST FIRST MI

Date of birth \_\_\_\_\_ Certificate no. \_\_\_\_\_ Social Security no. \_\_\_\_\_

Date of termination \_\_\_\_\_ Reason for termination \_\_\_\_\_

## B. Employer information

Group policy no. \_\_\_\_\_

Employer's name, address and telephone no. \_\_\_\_\_

## C. Employee portability information

I wish to continue life insurance on:  Myself  Myself/my dependent(s)

Your life amount currently in force: \$ \_\_\_\_\_  Tobacco user  Non-tobacco user

Name(s) of dependent(s) to be continued:

Spouse \_\_\_\_\_ Date of birth \_\_\_\_\_ Life amount currently in force \$ \_\_\_\_\_

Tobacco user  Non-tobacco user

Child(ren) *(If additional space is needed, please attach list.)*

1. \_\_\_\_\_ Date of birth \_\_\_\_\_ Life amount currently in force \$ \_\_\_\_\_

2. \_\_\_\_\_ Date of birth \_\_\_\_\_ Life amount currently in force \$ \_\_\_\_\_

## D. Survivor portability information

Name of person exercising portability \_\_\_\_\_ Relationship to employee \_\_\_\_\_

Name(s) of dependent(s) to be continued: Spouse:  Tobacco user  Non-tobacco user

Spouse \_\_\_\_\_ Date of birth \_\_\_\_\_ Life amount currently in force \$ \_\_\_\_\_

Child(ren) *(If additional space is needed, please attach list.)*

1. \_\_\_\_\_ Date of birth \_\_\_\_\_ Life amount currently in force \$ \_\_\_\_\_

2. \_\_\_\_\_ Date of birth \_\_\_\_\_ Life amount currently in force \$ \_\_\_\_\_

## E. Beneficiary for portable certificate

\_\_\_\_\_ BENEFICIARY NAME RELATIONSHIP

## F. Billing information and deposit premium

Applicant's home address \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
STREET ADDRESS APT. NO. TELEPHONE NO.

CITY STATE ZIP

\*Billing mode requested:  Monthly  Quarterly  Semi-annually  Annually

*\*(If total premium is less than \$15.00 per month, monthly billing mode is not available.)*

Premium submitted \$ \_\_\_\_\_ *(Must equal initial modal premium or 2 modal premiums for monthly billing; call toll free 866.909.6065, for premium rates.)*

*Note: All checks must be drawn to the order of Union Security Insurance Company, and if accepted, are subject to collection.*

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

## To be completed by Employer

I have reviewed all of the information above and certify that it is correct to the best of my knowledge.

\_\_\_\_\_  
SIGNATURE OF EMPLOYER TITLE DATE

**NOTICE OF PORTABILITY FOR INSURED EMPLOYEES  
AND SURVIVING DEPENDENTS UNDER VOLUNTARY LIFE**

**Employee and Survivor Portability:**

As a covered employee, if your insurance has ended, you may be eligible to continue your plan of group term life insurance and dependent life insurance. In addition, if you are a surviving dependent of a covered employee and your coverage is terminated because of the death of a covered employee, you may be eligible to continue your plan of group term life insurance. Please refer to your certificate of insurance from your Voluntary Group Term Life policy for details regarding your eligibility to exercise the portability option.

Any group accidental death and dismemberment insurance **will not** continue. You may not add or increase any amounts of insurance once you are eligible for or elect portability. Any Disability Benefit provision will not apply to your Portability certificate. All other provisions of the certificate (*including any suicide limitations*) will continue to apply. Please refer to the certificate for complete coverage information.

In order to continue your insurance, you must send Union Security Insurance Company the completed Portability Application on page 2 of this form within 31 days of your termination of insurance. For **Employee Portability**, complete all areas of the portability application except section D. For **Survivor Portability**, complete all areas of the application except section C. In addition, you must also submit your first modal premium to us with this application (or two modal premiums for monthly billing). To determine the initial premium required, call toll free 866.909.6065 for a quote. Upon approval, your certificate will become effective on the first of the month coinciding with or next following date of termination with no break in coverage.

Premiums under the portability policy are age-based and will advance as you and your spouse move to higher age brackets. Age is determined for premium purposes on each January 1.

Your portable term certificate will continue for as long as you continue to pay the modal premium, up to age 65 for Employee Portability and up to the spouse's age 65 for Survivor Portability. You may be eligible to convert your coverage to a separate, individual life policy at any time up to and including the date your portability certificate terminates.

If your employer is subject to Minnesota §61A.092, a Minnesota life continuation privilege may be available to you. If you choose to continue under this privilege, portability is available after your Minnesota continuation ceases.

**Mail your completed Portability Application and initial premium to:**

Union Security Insurance Company  
c/o Administrative Services  
300 Southborough Drive, Suite 200  
South Portland, ME 04106-6914