HOSPITAL PORTABILITY COVERAGE

What is Portability of Hospital Insurance?

As part of the Hospital coverage provided by your Employer, a feature was included in the policy to allow you and your spouse and children to continue this coverage when you terminate employment with the employer or are no longer in an eligible group. Portability of Hospital Insurance provides the same coverage you have at time of port. Different rates may apply.

Important facts to remember (See Portability of Hospital Insurance in your certificate)

- Portability is not available if the policy is cancelled by Unum.
- You may continue coverage for yourself, your spouse and/or children at the current benefit plan option. You may also choose to remove coverage for your spouse and/or children. If your employer's plan includes a lower option, coverage may also be lowered, but not increased.
- If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.
  - Otherwise, your ported coverage will end on the earliest of:
    - the date you fail to pay the required premium within 31 days of a premium due date;
    - the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
    - the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice
    - the date you die; or
    - for coverage sitused (state that governs the contract) in Kentucky, Ohio and Tennessee, the date the Employer's policy terminates.
  - Your Spouse's ported coverage will end on the earliest of:
    - the date your ported coverage ends;
    - the date your Spouse is no longer eligible for coverage;
    - the date your Spouse no longer meets the definition of a Spouse;
    - the date of your Spouse's death; or
    - the date of divorce or annulment.
    - If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage.
  - Your Children's ported coverage will end on the earliest of:
    - the date your ported coverage ends;
    - the date your Children are no longer eligible for coverage; or
    - the date your Children no longer meet the definition of Children.
  - Once ported coverage ends, it cannot be reinstated.

What are the Employer's responsibilities?

- Fully complete Section 1 of the election form and provide to the participant. Incomplete election forms may result in a denial of the applications.
- Determine if terminating employee is eligible to apply for Portability of Hospital Insurance (see certificate for detailed requirements).
- Provide separate election forms when portability is offered under more than one insurance policy.
- Provide premium rates and portability election forms to eligible termination employees eligible to port coverage.

What are the Employee's responsibilities?

- Fully complete Section 2. Sign and date the election form. Incomplete election forms may result in a denial of the application.
- Select if you want to keep existing or reduce coverage for you, your Spouse and your Children. Any changes to Children coverage applies to all eligible children. If you reduce coverage for yourself, coverage is automatically reduced for your spouse and children.
- An initial premium payment must be submitted by ACH form or check with this election form within 31 days from the date your coverage ends.
- Designate a beneficiary using the form provided.
- Send the election form and the initial premium payment to 2211 Congress Street, Attn: Portability Unit, Portland, ME 04122 or fax to 207-575-2993.
- Please remember to:
  - include the initial premium payment;
  - sign and date the election form with today's date;
  - designate a beneficiary;
  - contact us when your last child reaches age 26 to cancel child coverage.

Retain a copy of this for your records.

HOSPITAL PORTABILITY COVERAGE
Submit to: Unum Insurance Company (Unum) Portability Unit
2211 Congress Street, Portland, ME 04122 • 1-800-421-0344 • Fax 207-575-2993

Section 1: Employer Completes

Company Name:	Policy Number	Division	Class

Employee Name (Last, First, MI): ☐ Plan 1 ☐ Plan 2

Date Coverage Ends (mm/dd/yyyy):

Fill in Current Elected Coverage for Each Insured

Insurance Type	Hospital
Employee	☐ Yes ☐ No
Spouse	☐ Yes ☐ No
Child	☐ Yes ☐ No

Plan Administrator Name:

Plan Administrator Signature:

Plan Administrator Telephone Number:

Plan Administrator Email:

Section 2: Insured Completes

Insured Mailing Address (Street, PO Box, City, State, Zip):

Home Telephone:

Alternate Telephone:

Insured Social Security Number:

Insured Date of Birth (mm/dd/yyyy):

Gender: ☐ Male ☐ Female

Spouse Name: ☐ continue coverage ☐ drop coverage

Spouse Date of Birth (mm/dd/yyyy):

Spouse Social Security Number:

Child Coverage: ☐ continue coverage ☐ drop coverage

* Check the policy or your certificate. Child eligibility may be subject to age, student and/or marriage status.

Fill in Requested Coverage Amount:

Insured Type	Hospital
Insured	☐ Continue Coverage ☐ Reduce Coverage (subject to availability)

ALL PREMIUMS TO BE PAID MONTHLY VIA AUTOMATIC PAYMENT. Please complete and send in the enclosed Authorization and Agreement for Automatic Payments form with your application.

☐ I am opting out of monthly payments and want to pay by check or money order (made payable to Unum) with the following option:
☐ Quarterly (Every three months) ☐ Semi-Annually (Every six months) ☐ Annually (One time per year)

I understand and agree to the following:
Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Unum Hospital insurance coverage under which this coverage is being offered and is subject to satisfaction of the conditions provided therein.

Insured Signature:	Today's Date (mm/dd/yyyy):	Insured's Email Address

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.

PORTABILITY BENEFICIARY DESIGNATION FORM
2211 Congress Street
Portland Maine 04122
Phone: 1-800-421-0344
Fax: 207-575-2993

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper.

PART 1: Information About You

Name (Last Name, Suffix, First Name, MI)

Social Security Number

Policy Number

Division

BL Number
BL

PART 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Hospital Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Telephone Number	Relationship	Social Security Number	Date of Birth	Percent
					Total Must Equal 100%

PART 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Telephone Number	Relationship	Social Security Number	Date of Birth	Percent
					Total Must Equal 100%

PART 4: Signature

X _____ _____

Signature **Date**

Unum Insurance Company
Authorization and Agreement for Automatic Payments
Drawn By and Payable To:
Unum Insurance Company (hereinafter referred to as "the Company")
2211 Congress Street, Portland, Maine 04122
1-800-421-0344 Fax number: 207-575-2993
email to: PortabilityConversion@unum.com

PLEASE PRINT

BL#/POLICY NUMBER	INSURED NAME	SOCIAL SECURITY NUMBER

☐ Please apply this to all my policies

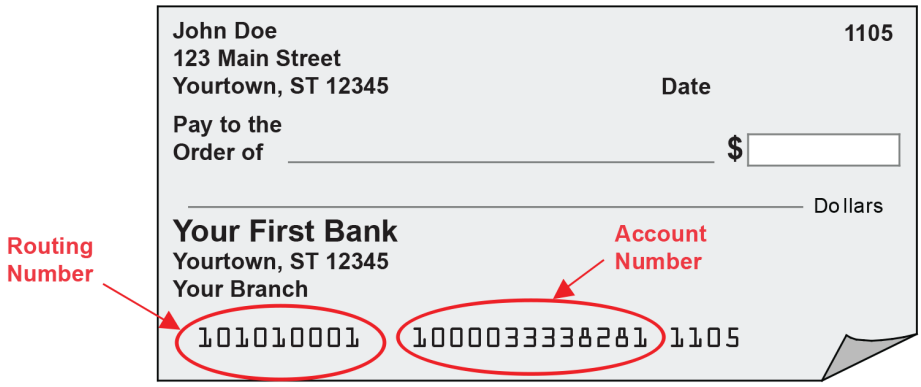
1. Purpose for submitting this authorization form:
   ☐ New Preauthorized payment plan ☐ Change in bank
   ☐ Addition of new policy to plan ☐ Change in account number

   Type of Account:
   ☐ Checking
   ☐ Savings

2. Current Address: _____
3. Name of Banking Institution: _____
4. Name on Bank Account: _____
5. Routing Number (9 digits): ___ ___ ___ ___ ___ ___ ___ ___ ___
6. Account Number: _____

Refer to the sample check for help locating the Routing Number and Account Number. Attach or scan a Voided Check (optional).

Sample Check



APPLICANT INFORMATION FOR BANK:

You are hereby authorized, as a convenience to me, to pay and charge to my account any check or electronic fund transfer drawn on this account on the first of the month by and payable to the order of the company(s) indicated above for itself (themselves), provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or transfer shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice and you have had a reasonable time to act on it. I agree that you shall be fully protected in honoring any such check or transfer.

I further agree that if any such check or transfer be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Signature of Depositor	Date
Please print name as signed above	

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL