

Please print (preferably in black ink).

EMPLOYEE INFORMATION

Employee's Name (First): _____ (Last): _____ (Middle Initial): _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Birth date: _____ Social Security Number: _____
(Month/Day/Year)
Day Phone: _____ Evening Phone: _____

3.

Voluntary Coverage

- Continue amount of coverage currently in force
- Decrease the coverage amount to \$ _____
(Units of \$1,000)
- *Increase your coverage to \$ _____
(Units of \$1,000)

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

Employee Name: _____

Social Security Number: _____

BENEFICIARY INFORMATION

Beneficiary Name (Employee Coverage)	Percentage Total: 100%	Social Security Number	Date of Birth (Month/Day/Year)	Relationship
	%			
	%			
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
	%			
	%			

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Complete this section only if the current Owner is other than the Employee.

Owner - The Owner is the person who has the right to assign, surrender, and exercise all other rights contained in the contract. If no other Owner is designated, the Employee shall be the Owner. All correspondence and premium notices will be mailed to the Owner. If you wish to designate someone other than yourself as the owner, an assignment form must be completed.

Owner Name: _____ Tax I.D./Social Security Number: _____

Street Address: _____ Telephone Number: _____

City: _____ State: _____ Zip Code: _____

Please sign and date here



Owner's Signature: _____ Date: _____
(Must be signed by Owner if other than employee.) (Month/Day/Year)

Employee Name: _____

Social Security Number: _____

Eligibility - Age limitations may exist which will limit your eligibility to continue your coverage. These limitations may be reviewed in your 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 continue as an individual, please call 1-800-423-1282 soD 14 >>BD1T
3. Deadline - You have 31 days from the coverage end date to exercise the Portability Option. If you were not notified of this right at least 15 days prior to the end of the 31-day period, you will have 15 days from the date notice is given to submit your Portability application to continue coverage. In no event will this period be extended beyond 91 days.
- 4.
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.
- 7.
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 your Certificate for details).
- 9.