CHUBB®

CRITICAL ILLNESS INSURANCE: REQUEST FOR PORTABILITY OF COVERAGE

Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
CWBPortabilityConversion@chubb.com | 833-542-2013

IMPORTANT INFORMATION WHEN CONSIDERING PORTABILITY COVERAGE

When your Critical Illness insurance coverage ends, either because your employment has terminated or you are no longer eligible to participate in your employer's Group Critical Illness policy, you may be eligible to port your policy. Portability allows you to continue (or 'port') your coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer's Critical Illness policy. **Some key considerations are:**

- Portability is not available to employees who are no longer actively at work due to a disability or leave of absence.
- Portability allows you, your spouse or child(ren) to continue (or "port") Critical Illness coverage at group rates.
- The ported coverage will be subject to the same provisions contained in your employer's Group Critical Illness insurance policy.
- Employees may only request to continue their current coverage.
- Employees may not increase a benefit when porting coverage.
- Continued coverage may be canceled by Chubb if the Employee:
  - fails to pay required premium within the policy's grace period for payment;
  - is rehired and becomes eligible under the group policy; or
  - dies.

What are the Employer's responsibilities?

- Fully complete Section 1 of the request form and provide to the participant. Incomplete request forms may result in a denial to continue coverage.
- Determine if terminating employee is eligible to apply for portability of Critical Illness Insurance.
- Provide separate request forms when portability is offered under more than one insurance policy.
- Provide premium rates and portability request forms to eligible terminating employees.

What are the Employee's responsibilities?

- Fully Complete Section 2. Sign and date the request form. Incomplete request forms may result in a denial to continue coverage.
- Select the amount of coverage to be continued.
- Send the request form to the mailing or email address listed at the top of page 1, within the deadline to request portability.
- Please remember to sign and date this request form with today's date; and retain a copy of this for your records.

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EMPLOYER COMPLETES SECTION 1

COMPANY NAME: **Salem Health**	GROUP POLICY NUMBER(S): **100005745** DIVISION: **N/A** CLASS: **N/A**	
EMPLOYEE LEGAL NAME (LAST, FIRST, MI):	EMPLOYEE HIRE DATE: EMPLOYEE JOB TITLE:	
DATE COVERAGE ENDS (MM/DD/YY): LAST PAYROLL DEDUCTION DATE:	INSURED ON DISABILITY OR SICK LEAVE WHEN TERMINATED? □ Yes* □ No *If yes, date premium paid to:	REASON FOR LOSS OF COVERAGE: □ Terminated □ Retired □ Reduced Hours (must be working) □ Other:

FILL IN CURRENT COVERAGE AMOUNTS FOR EACH INSURED AND INSURANCE TYPE

COVERED INSURED	CRITICAL ILLNESS COVERAGE AMOUNT
EMPLOYEE	
SPOUSE	
CHILD	
TOTAL PREMIUM	

PLAN ADMINISTRATOR
NAME:
PHONE:
EMAIL:
SIGNATURE:

EMPLOYEE COMPLETES SECTION 2

Insured Mailing Address (Street, PO Box, City, State, Zip)			Home Phone: ALT Phone:
INSURED SOCIAL SECURITY NUMBER (SSN):	INSURED DATE OF BIRTH (DOB) (MM/DD/YYYY):		SEX: □ MALE □ FEMALE
SPOUSE NAME:	SPOUSE DOB:	SPOUSE SSN:	
CHILD NAME:	*CHILD DOB: CHILD SSN:	CHILD NAME:	*CHILD DOB: CHILD SSN:
CHILD NAME:	*CHILD DOB: CHILD SSN:	CHILD NAME:	*CHILD DOB: CHILD SSN:
* Per your policy, child eligibility may be subject to age, student and/or marriage status.			
HAVE YOU USED TOBACCO PRODUCTS IN THE PAST TWELVE MONTHS? □ Yes* □ No		HAS YOUR SPOUSE USED TOBACCO PRODUCTS IN THE PAST TWELVE MONTHS? □ Yes* □ No	

FILL IN REQUESTED COVERAGE AMOUNT FOR EACH INSURED TO BE PORTED. COVERAGES LEFT BLANK WILL RESULT IN THE AMOUNT OF $0.

INSURED TYPE	CRITICAL ILLNESS COVERAGE AMOUNT	NOTE:
EMPLOYEE	$	You may not increase coverage amounts and the amount must be available etc.
SPOUSE	$	
CHILD	$	Child eligibility may be subject to age, student and/or marriage status, per the group policy.

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 understand and agree to the following:
Any coverage chosen on this request form will only be issued in accordance with the portability provision contained in the Employer's Group Critical Illness policy under which this coverage is being offered, and is subject to satisfaction of the conditions provided therein. Once a request for portability has been received and approved, portable coverage will be effective the day after coverage would have otherwise ended under the Employer's policy, so long as your initial premium payment is received.

SIGNATURE:	TODAY'S DATE (mm/dd/yyyy):	EMAIL:

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

INSTRUCTIONS: Any coverage that may be issued pursuant to this request for portability requires you to submit a new beneficiary designation form. 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

LEGAL NAME (LAST, SUFFIX, FIRST, MI):
SOCIAL SECURITY NUMBER:

PART 2: PRIMARY BENEFICIARY (IES)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life 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	PHONE	RELATIONSHIP	SSN	DOB	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	PHONE	RELATIONSHIP	SSN	DOB	PERCENT
					TOTAL MUST EQUAL 100%

PART 4: SIGNATURES

SIGNATURE:	**TODAY'S DATE (MM/DD/YYYY):**

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INDIVIDUAL AUTOPAY PREMIUM COLLECTION AGREEMENT AND AUTHORIZATION

NAME: _____

EMAIL: _____

PHONE: _____ **FAX:** _____

I, the individual who is signing below, hereby authorize Combined Insurance Company of America ("Combined"), a Chubb Company, to initiate electronic debt entries or to effect a change by any other commercially accepted method, to my bank account (as shown below) in the financial institution named below (hereafter called Depository). I specifically authorize Depository to debit my account on a monthly basis to pay premiums for the insurance for which I have applied today. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination. I understand that such notification from me must be given with sufficient time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I also authorize combined to change the amount of my debit: (1) to correct clerical errors in the initial premium calculation for the above selected coverage(s) and (2) to reflect changes in premium resulting from Combined's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my debit are to be made only at the direction of Combined and such change(s) does not require any other subsequent or additional authorization by me.

I understand that if premiums are not paid within the grace period under the subject policy(ies) or certificate(s), as in the event withdrawals are dishonored, the policy(ies) or certificate(s) will terminate. However, certain life insurance policies may contain non-forfeiture provisions and/or automatic premium loan provisions which may extend coverage for a period of time. The specific provisions of each policy will govern.

DEPOSITOR NAME: _____

(PLEASE PRINT)

DEPOSITOR SIGNATURE: _____

(SIGNATURE MUST BE THE SAME AS ON FILE AT THE BANK/FINANCIAL INSTITUTION.)

BANK NAME: _____

CITY: _____ **STATE:** _____

ROUTING (ABA) NUMBER: _____

ACCOUNT NUMBER: _____

ATTACH A VOIDED CHECK HERE