CHUBB®

LIFETIME BENEFIT TERM 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:

What are your responsibilities as the employee?

- Complete Section 1 and 2 of this request form and the Beneficiary Designation Form. Incomplete forms may result in a denial to continue coverage
- Determine the amount of coverage you want to port. You may port an amount less than or equal to the amount you, your spouse or child(ren) had in force with your Employer.
- If you wish to elect coverage in an amount other than your current coverage amount, provide the requested amounts.
- Coverage is subject to the minimum and maximum limits provided in the employer's policy. Contact your employer for a copy of the group life insurance policy.
- Please remember to (1) include your ACH form; (2) sign and date this request form; (3) designate a beneficiary; and (4) retain a copy of this entire form for your records.
- Mail or email completed forms to the address listed at the top of the request form within the deadline for portability specified in the Certificate.

What should you know when completing your Beneficiary Designation Form?

- **Primary Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).
- **Contingent Beneficiary(ies)** means the person(s) you choose to receive your insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).
- **Minor Beneficiary(ies)** – When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a child's court-appointed financial guardian. The regulations governing minor beneficiaries vary by state.
- **Trust** – You may designate a valid trust as a beneficiary.
- **Updates to Your Beneficiary Designation** – You can change your beneficiary designation at any time. You may wish to review your designation periodically.
- **Consult an Attorney** – This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attor-ney to help ensure your beneficiary designation correctly reflects your intentions.

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GENERAL INFORMATION - COMPLETE SECTION 1

COMPANY NAME:	GROUP POLICY NUMBER(S): DIVISION: CLASS:	
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

INSURED TYPE	LIFETIME BENEFIT TERM	PREMIUM	CERTIFICATE NUMBER
EMPLOYEE			
SPOUSE			
CHILD			

EMPLOYEE COMPLETES SECTION 2

Employee 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 AMOUNTS FOR EACH INSURED - COVERAGES LEFT BLANK WILL RESULT IN A COVERAGE AMOUNT OF $0. COVERAGE REDUCES ACCORDING TO YOUR EMPLOYER'S GROUP INSURANCE POLICY.

INSURED TYPE	LIFETIME BENEFIT TERM	PREMIUM	CERTIFICATE NUMBER
EMPLOYEE			
SPOUSE			
CHILD			

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 requested on this form will be issued in accordance with the portability provision contained in the Employer's Lifetime Benefit Term policy under which this coverage is being offered, and is subject to satisfaction of the conditions therein. Once a request for portability of Lifetime Benefit Term has been received and approved, so long as your initial premium payment is received with your request and has been honored by your financial institution, the Effective Date for your new coverage will be the day after your coverage under your Employer's Group Policy has terminated.

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

EMPLOYEE NAME: _____

EMAIL: _____

PHONE: _____ **FAX:** _____

I have agreed to deduct from each employee's wages, the premiums for the voluntary insurance coverage each employee has selected and agreed to purchase from Combined Insurance Company of America ("Combined Insurance") by payroll deduction through the Combined Insurance supplemental benefits program. By my signature below, I authorize Combined Insurance to collect these premiums by initiating electronic debit entries or effecting a change by any other commercially accepted method, to the checking account noted below in the financial institution named below, (hereinafter called Depository). I specifically authorize Depository to debit this account on a monthly basis to pay the premiums for those employees' Combined Insurance policies, where such premiums have previously been deducted from the employees' wages. This authority is to remain in full force and effect until Combined Insurance 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 Insurance and Depository a reasonable opportunity to act.

Combined Insurance also agrees to notify me each month of the amount to be debited from the account noted below. Combined Insurance's notification shall be at least three days prior to the date that the below noted account will be debited. Combined Insurance further agrees that it will modify the amount to be debited when so notified by me on or before the scheduled debit date.

DEPOSITOR NAME: _____
(PLEASE PRINT)

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

BANK NAME: _____ **DEBIT DAY:** _____

CITY: _____ **STATE:** _____

ROUTING (ABA) NUMBER: _____

ACCOUNT NUMBER: _____

ATTACH A VOIDED CHECK HERE