Request for Portability of Supplemental Employee & Dependent Life Insurance

UnitedHealthcare

This form must be received by UnitedHealthcare within 31 days of Date of Termination of Coverage.
PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETE FOR US TO PROCESS YOUR REQUEST.

Sections A, B and C to be completed by Employer

A. Employer Information about EMPLOYEE

Employee Last Name	First Name	M.I.	Date of Birth	Date of Hire

Employee's Supplemental Coverage Amount	Social Security Number
Annual Salary at Termination	Date of Coverage Termination

Was the Employee insured under this life policy or the one it replaced for at least 3 months*? ☐ Yes ☐ No

Was the Employee actively at work at the time of their termination? ☐ Yes ☐ No **If "No" please answer the following**:

Did the Employee's employment terminate as a result of not being actively at work due to sickness or injury? ☐ Yes ☐ No

NOTE:

- The Employee will not be eligible to Port the Life Insurance Coverage if not insured under this life policy or the one it replaced for at least 3 months*
- The Employee will not be eligible to Port the Life insurance Coverage if termination of employment was due to a sickness or injury

Refer to the Policy for the definition of actively at work and other portability eligibility conditions

B. Employer Information about Spouse and Dependent(s) (Complete only when the Dependent Portability option is available.)

Dependent Name and Relationship	Social Security Number	Date of Birth	Coverage Amount

C. Employer Information

Employer's Signature	Printed Name	
Company Phone Number	Date	
Employer Name	Group Policy Number	Date Given to Employee

Sections D, E, F, G, H and I to be completed by Employee

D. Employee Information

Address (Street, City, State and ZIP Code) Phone Number

E. Insurance Being Ported

Check appropriate election (you may only port coverage that is shown above by your employer as being in force):

☐ Employee Supplemental Life
☐ Employee and Dependent Spouse ☐ Employee and All Dependents ☐ Employee and Dependent Children

F. Amount of Insurance Being Ported

Employee Supplemental Life $ **(An Amount for Employee Supplemental Life is Required)**

Dependent Spouse $

Dependent Children $

***Time period may vary by state, please see your Certificate of Coverage.

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G. Premium Calculation (see attached calculation sheet for details)

Please indicate Quarterly or Annual Billing:

☐ Quarterly ☐ Annual

Have you or your dependents used tobacco of any kind during the last twelve months? ☐ Yes ☐ No

If Yes, who? ☐ Employee ☐ Dependent Spouse ☐ Dependent Child

Employee's premium amount: $_____

Spouse's premium amount: $_____

Dependent's premium amount: $_____

Total payment required with this form (Employee + Spouse+ Dependents): $_____

H. Beneficiary Information

Employee's Beneficiary

Relationship

Address

I. Employee Signature

I have been notified of my option for ported coverage. I understand that I must exercise my right to port within 31 days of the date my group coverage ends. **Enclosed with this form is my first quarterly OR first annual premium.** I hereby authorize the insurer to begin billing me directly for my Supplemental Life Insurance Plan.

Insured Employee Date

Make your check payable to UnitedHealthcare. Mail this completed form with your premium to:

UnitedHealthcare
9700 Health Care Lane – 7th Floor
MN017-W700
Minnetonka, MN 55343

Please retain your Group Certificate from your former Employer. A separate Portability certificate will not be issued.

Please direct Portability inquiries to 1-877-683-8601

UnitedHealthcare Specialty Benefits insurance products are underwritten by UnitedHealthcare Insurance Company (rated A+ by Standard & Poors), Unimerica Insurance Company (rated A by A.M. Best), Unimerica Life Insurance Company (rated A by A.M. Best). Some products may not be available in certain states.

UnitedHealthcare Use Only

Date Received	Group Number

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Portability Premium Rates

Current Rates for Term Insurance

	Non-Tobacco Rates per $1,000 of Insurance		Tobacco Rates per $1,000 of Insurance	
Your Age	**Quarterly**	**Annual**	**Quarterly**	**Annual**
Less than 25	$0.24	$0.96	$0.36	$1.44
25 - 29	$0.24	$0.96	$0.39	$1.56
30 - 34	$0.27	$1.08	$0.42	$1.68
35 - 39	$0.33	$1.32	$0.51	$2.04
40 - 44	$0.39	$1.56	$0.63	$2.52
45 - 49	$0.69	$2.76	$1.11	$4.44
50 - 54	$1.02	$4.08	$1.62	$6.48
55 - 59	$1.98	$7.92	$3.18	$12.72
60 - 64	$2.79	$11.16	$4.47	$17.88
65 - 69	$4.53	$18.12	$6.78	$27.12
70 - 74	$8.52	$34.08	$11.85	$47.40
75 – 79	$15.42	$61.68	$20.37	$81.48
80 – 84	$28.29	$113.16	$32.40	$129.60
85+	$46.08	$184.32	$50.31	$201.24

How to Calculate your Premium:	***Example:***
Determine whether you wish to pay your premium quarterly or annually.	*A 50 year old decides to continue their life coverage and pay premiums quarterly.*
Have you used tobacco of <u>any kind</u> during the last twelve months? ☐ No ☐ Yes If no, you are eligible for our non-tobacco rates; if yes, you must pay the Tobacco rates.	*They have not used tobacco of any kind in the past twelve months.*
Find your rate on the chart above. The rate is based on your answer to the tobacco use question above and age at the time your coverage begins, which is 31 days from the time your group coverage terminates or is reduced. As your age increases, your rate will increase as well.	*The quarterly rate for a 50 year old non-tobacco user is $1.02 for each $1,000 of insurance.*
Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.	*The person wants the amount he had under his group plan: $50,000*
Premium Calculation:	
a. Rate per thousand of dollars of coverage from chart: $_____	*a. $1.02 (Quarterly Non-Tobacco use rate)*
b. The number of thousands of coverage you want: $_____	*b. 50 ($50,000 of coverage divided by $1,000)*
c. Multiply a times b. This is your premium: $_____	*c. $51.00 ($1.02 multiplied by 50)*
If you are requesting portability coverage for your spouse and/or dependents, a similar calculation should be done for each individual.	