PORTABILITY OF INSURANCE FOR FORMER DEPENDENT CHILD

Life Insurance Company of North America

CIGNA Group Insurance
Life • Accident • Disability

Please print (preferably in black ink).

EMPLOYER USE SECTION: TO BE COMPLETED BY THE EMPLOYER

Employer______________________________ Policy # ______________

Name of Employee______________________________ Social Security Number ______________

Dependent Child Coverage Termination Date: ______________ *Month/Day/Year*

Reason for Dependent Child's Coverage Termination:

Age   No Longer Full-Time Student   Other ______________________________

Have premiums been paid for this child through the coverage termination date: Yes   No

Employer Signature______________________________ Date ______________ *Month/Day/Year*

NOTE TO EMPLOYER: Please review the group policy regarding portability limitations.

TO BE COMPLETED BY EMPLOYEE:

Please print (preferably in black ink).

Former Dependent
Child's Name______________________________ Social Security Number ______________

Gender: Male   Female   Birthdate ______________ *Month/Day/Year*

Street Address______________________________ City______________ State________ Zip__________

Day Phone ______________ Evening Phone ______________

TO BE COMPLETED BY FORMER DEPENDENT CHILD:

1. Indicate the amount of coverage you wish to continue: $25,000 $50,000*

   * Please note, the Insurance Company will issue you $25,000 of coverage as guarantee issue, but you will need to satisfy medical evidence of insurability to obtain $50,000 of coverage. The Insurance Company will send you an evidence of insurability form to complete.

2. You must specify a beneficiary(ies) by completing the section below. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each and the total must equal 100%. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

Beneficiary	*Percentage*	*Social Security #*	*Date of Birth* *Month/Day/Year*	*Relationship*

Please Sign Here

Former Dependent
Child's Signature______________________________ Date ______________ *Month/Day/Year*

LM-600827b (08/06)

Former Dependent
Child's Name________________________________ Social Security Number ____________________

GENERAL INFORMATION

1. **Eligibility** — Children who were covered but are no longer eligible due to reaching the maximum age stated in the certificate of insurance under either parent's Term Life program. You have 31 days from the date of no longer being eligible to apply for portability.

2. **Coverage Options** — You can elect either $25,000 or $50,000 in life coverage. The first $25,000 is guaranteed. If applying for $50,000, you must satisfy the insurability requirements for the amount over $25,000.

3. **Rates** — Please note that rates for ported coverage will be higher than those paid previously, and they are subject to change. If you would like an estimated premium before applying for coverage, please call 1-800-423-1282.

4. **Deadline** — You have 31 days from the Coverage Termination Date to exercise the portability option.

5. **Effective Date** — The effective date of your ported coverage will be the first day of the month following the Coverage Termination Date.

6. **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.

7. **Beneficiary(ies)** — In the event of your death, benefits will be paid to the beneficiary, the person named on page 1 of this document. Changes may be made to the beneficiary by sending written notice to the address below.

Complete this form, sign and date, and return to: NEBCO, P.O. Box 152501, Irving, TX 75015-2501

For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.