USAble Life
PO Box 1650
Little Rock, AR 72203-1650

Voluntary/Group Term Life
Portability Premium Calculation

An employee terminating employment may continue coverage up to the amount of the Voluntary/Group Term Life in effect at the time of termination. If an employee continues coverage, the employee's spouse may also continue coverage. Children may not continue coverage under the "portability" provision but may be eligible to convert coverage to a Whole Life policy.

Eligibility: To be eligible to continue coverage the applicant must be under age 70 or 65 if retired and may not be disabled. Portability is not available upon policy cancellation.

Application: Within 31 days of the date of termination from the group, the employer and employee should complete an "Application For Continuation of Group Life," form GRP-PORT-APP (5-09), and send it to USAble Life.

The first premium must accompany the application. You must submit the application and premium payment within 31 days from the date of termination from the group.

Premium: Premiums will be billed directly to the employee and may be billed annually, semi-annually or quarterly. Monthly billed or "bank withdrawal" is not available.

Unismoker Rates for Employees and Spouses
Per $ 10,000 Unit

Ages	Annual	Semi-Annual	Quarterly
Under 30	$ 11.04	$ 5.52	$ 2.76
30 – 34	16.56	8.28	4.14
35-39	22.08	11.04	5.52
40-44	36.00	18.00	9.00
45-49	58.08	29.04	14.52
50-54	93.84	46.92	23.46
55-59	160.08	80.04	40.02
60-64	229.20	114.60	57.30
65-69	369.84	184.92	92.46

Important Note:
Coverage reduces 50% of the pre-age 65 amount at age 65 and terminates at age 70, or age 65 if portability was due to retirement.

Example

Employee age 45 and spouse age 43, neither are smokers, each wish to continue their coverage. The employee has $50,000 and the spouse has $20,000. They want to be billed semi-annually.

Employee	$29.04 x 5 units =	$145.20
Spouse	$18.00 x 2 units =	$ 36.00
Total semi-annual premium due		$181.20

Premium Worksheet

	Table Rate	x Per $10,000	Premium
Employee	_____	x _____	= _____
Spouse	_____	x _____	= _____

For assistance or questions, please contact Customer Service at 800-370-5856. Application forms are available at: www.usablelife.com.

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

Application for Portability of Group Term Life

Office Use Only	
Policy #	
Effective Date	
Group #	

SECTION A - APPLICANT INFORMATION

Name (First, MI, Last)			Social Security No.	
Home Address	City	State	Zip	County
Date of Birth / Age	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Home Phone	
Date of Termination of Employment	Reason for termination: ☐ Disabled ☐ Retired ☐ _____		Are you a fulltime member of the armed forces of any country? ☐ Yes ☐ No	

Have you or your spouse used tobacco products in the past year?
Employee ☐ Yes ☐ No Spouse (if applying for coverage) ☐ Yes ☐ No

SECTION B - EMPLOYER INFORMATION (This section is to be completed by the Employer)

1. Employer Name	Group Policy Number
2. Did the Insured Employee terminate his employment due to disability? ☐ Yes ☐ No Did the Insured Employee terminate his employment due to retirement? ☐ Yes ☐ No	Date Applicant's Employment Terminated

SECTION C – PLAN INFORMATION

1. Current Amount of Term Life on Employee: $_____
2. Current Amount of Term Life on Spouse: $_____ Continue Spouse's Term Life? ☐ Yes ☐ No
3. Premium Mode: ☐ Quarterly ☐ Semi-Annually ☐ Annually

SECTION D – SPOUSE INFORMATION (Complete only if applying for Portability of Spouse's Group Life Coverage)

Name (First, MI, Last)	Social Security No.	Date of Birth	Sex

SECTION E – BENEFICIARY This will revoke any existing beneficiary designations you may have under these benefits.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at applicant's death):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
				Total must equal 100%	=

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
				Total must equal 100%	=

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded. Further, my signature below acknowledges that I have received a copy of this application. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary.

Warning - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

Signed at _____ (City) _____ (State) on _____ (Month Day Year) X _____ (Signature of Applicant)

EMPLOYER'S STATEMENT: I represent the above information is true, complete, and correctly recorded. X _____ (Employer's Signature)

SECTION F - DECLINATION

I have been informed of my option to continue my group term life coverage. The Portability provision has been explained to me, and I have been given the opportunity to continue this coverage. I understand my option and decline such coverage.

_____ Signature of Terminating Employee

_____ Signature of Witness