



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-NC (5-09), and send it to US Able 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 =	<u>\$ 36.00</u>
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.



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HOME OFFICE USE ONLY	
Policy #	
Effective Date	
Group #	

APPLICATION | PORTABILITY OF GROUP TERM LIFE

SECTION A - APPLICANT INFORMATION

Name (First, MI, Last)				Social Security No.	
Home Address		City	State	Zip	County
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Home Phone	
Employment Termination Date	Reason for termination: <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> _____			Are you a fulltime member of the armed forces of any country? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or your spouse used tobacco or nicotine products in the past year? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse (if applying for coverage) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the Insured Employee terminate his employment due to retirement? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Current Amount of Term Life on Children:	\$ _____	Continue Children's Term Life? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Premium Mode:	<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> 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
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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%					=



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In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief. 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 - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed in _____ on _____
City State Month Day Year Signature of Applicant

EMPLOYER'S STATEMENT:

I represent the above information is true, complete, and correctly recorded.

Signature of Employer

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