LIFETIME BENEFIT TERM INSURANCE - REQUEST FOR PORTABILITY OF COVERAGE

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Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
Email: CWBPortabilityConversion@Chubb.com; Toll Free Number: 866-445-8574.

GENERAL INFORMATION - COMPLETE SECTION 1

Company Name:	Group Policy Number Division Class
Employee Legal Name (Last, First, MI):	Employee Hire Date: Employee Job Title:

Date Coverage Ends (mm/dd/yyyy):	Insured on disability or sick leave when terminated? ☐ Yes* ☐ No	Reason for Loss of Coverage: ☐ Terminated Employment ☐ Retired ☐ Reduced Hours (must be working) ☐ Other - Explain
Current Annual Earnings:	*If Yes, date premium paid to: _____	

Fill in Current Coverage and Premium Amounts for Each Insured

Insured Type	**Lifetime Beneft Term**	**Premium**
Employee		
Spouse		
Child		

Plan Administrator Name: Plan Administrator Signature:

Plan Administrator Telephone Number: Plan Administrator Email:

EMPLOYEE COMPLETES SECTION 2

Employee Mailing Address (Street, PO Box, City, State, Zip):		Home Telephone: Alternate Telephone:
Insured Social Security Number:	Insured Date of Birth (mm/dd/yyyy):	Sex: ☐ Male ☐ Female
Spouse Name:	Spouse Date of Birth (mm/dd/yyyy):	Spouse Social Security Number:

Child Name:	Date of Birth: *	Child Name:	Date of Birth: *
Child Name:	Date of Birth: *	Child Name:	Date of Birth: *

* 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.

Type	Lifetime Benefit Term Life	
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 Address:

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.

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LIFETIME BENEFIT TERM INSURANCE
PORTABILITY BENEFICIARY DESIGNATION FORM

Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
Email: CWBPortabilityConversion@Chubb.com; Toll Free Number: 866-445-8574.

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

Name (Last Name, Suffix, First Name, MI)

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Group Policy Number ☐☐☐☐☐☐ Division ☐

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	Telephone Number	Relationship	Social Security Number	Date of Birth	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	Telephone Number	Relationship	Social Security Number	Date of Birth	Percent
					Total Must Equal 100%

PART 4: Signature

X

_____ _____

Signature **Date**

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Individual Automatic Premium Collection Agreement and Authorization

Employee Name: _____

Email: _____ Phone: _____

I, the individual who is signing below, hereby authorize Combined Insurance Company of America ("Combined"), a Chubb company, to initiate electronic debit entries or to effect a change by any other commercially accepted method, to my checking account (as shown below) in the financial institution named below (hereinafter called Depository). I specifically authorize Depository to debit my account on a monthly basis to pay premiums for the insurance for which I have applied today. This authority is to remain in full force and effect until Combined 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 and Depository a reasonable opportunity to act on it. I also authorize Combined to change the amount of my debit: (1) to correct clerical errors in the initial premium calculation for the selected coverage(s) and (2) to reflect changes in premium resulting from Combined's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my debit are to be made only at the direction of Combined and such change(s) does not require any other subsequent or additional authorization by me.

I understand that if premiums are not paid within the grace period under the subject policy(ies) or certificate(s), as in the event withdrawals are dishonored, the policy(ies) or certificate(s) will terminate. However, certain life insurance policies may contain non-forfeiture provisions and/or automatic premium loan provisions, which may extend coverage for a period of time. The specific provisions of each policy will govern.

Depositor Name: _____
(Please Print)

Depositor Signature: _____ _____
(Signature must be the same as on file at the bank/financial institution.) (Date)

Preferred draft date of each month: ☐ Draft Amount $ ☐

TYPE OF COVERAGE	POLICY/CERTIFICATE NUMBER

Complete the information below or attach a voided check.

Name of Bank

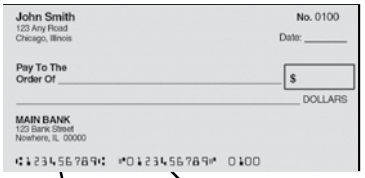
City & State of Bank

Routing (ABA) Number (9 digits)

Account Number

Account Type

☒ Checking



9 DIGIT ROUTING NUMBER

ACCOUNT NUMBER

Important Information

What type of coverage can be ported?

- **Basic Life** is insurance that your employer provided for you when you were in active employment.
- **Voluntary Life** is insurance elected by you for which you paid the premiums when you were in active employment.
- **Riders** included in your policy for which you paid the premiums when you were in active employment.

What are your employer's responsibilities?

- Fully complete Section 1 of this request form and provide it to the employee. Incomplete request forms may result in a denial of coverage.
- Provide the current monthly premium to the employee.

What are your responsibilities as the employee?

- Complete Section 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 request to port an amount less than or equal to the amount you, your spouse or child(ren) had in force with your Employer. Ported coverage cannot exceed the lesser of 5x your earnings, the maximum allowed under your plan, or $250,000 across all Chubb Life coverage.
- If you wish to request 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 Lifetime Benefit Term 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 attorney to help ensure your beneficiary designation correctly reflects your intentions.