



Portability Option for Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Read This Instruction Page Carefully

Instructions

<p>1. Employer</p> <p><i>Please Print</i></p>	<ul style="list-style-type: none"> • Complete the "Portability Option for Group Term Life Insurance" section of the application. • Be sure that: <ul style="list-style-type: none"> • All items are completed. • The form is signed by your authorized representative. • Return the application to your employee instructing them to complete the "Request for Portability of Group Term Life Insurance" section of the application.
<p>2. Employee</p> <p>Please read the Fraud Notice on the back of the form, before completing.</p> <p><i>Please Print</i></p>	<ul style="list-style-type: none"> • Complete the "Request for Portability of Group Term Life Insurance" section of the application in its entirety. <ul style="list-style-type: none"> • Consult the Rate Tables and instructions (included in the kit) to determine insurance amounts and costs. • Consult the Portability Plan Outline for the: <ul style="list-style-type: none"> - Guaranteed Standard Issue amount (GSI); and - Portability Maximum <p>If the two amounts are the same, evidence of good health will not be required for the coverage that you are requesting. If the Portability Maximum is more than the GSI and you are requesting more than the GSI, evidence of good health will be required for amounts above the GSI. If Aetna sees on your application that you are applying for more than the GSI, Aetna will send you an Evidence of Insurability form which you must complete and return to Aetna within 31-days of the date the form is sent to you.</p> <p>If after Aetna reviews the medical information you are approved for the coverage that you have requested, Aetna will send you a bill for the additional coverage, so the check that you are sending to Aetna with the application should not be for more than the GSI. Once you receive the bill you will have 31 days to pay for the amount that is above the GSI. If your payment is not received within 31 days, your coverage amount will be limited to the GSI.</p> <p>If Aetna is not able to approve your request for the amount that is above the GSI, your coverage will be limited to the GSI, however, you will have the option to convert the coverage that Aetna was not able to approve to an individual whole life policy, provided your application for conversion coverage is returned to Aetna within 31 days of the date on the conversion letter.</p> • Be sure that: <ul style="list-style-type: none"> • All items are completed. • The form is signed by you. • Make a copy of the application for your records and mail the original to: <p style="margin-left: 40px;">Aetna Life Insurance Company Group Insurance 151 Farmington Avenue Hartford, CT 06156-7350</p> <p>If you have any questions, call us toll-free at: 1-800-826-7448</p>

Please call Aetna's toll-free number if you have any questions about how to complete the Request for Portability of Group Term Life Insurance form.



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Request for Portability and payment of the first premium due for the frequency chosen must be made within 31 days after the date the employee's group insurance terminates.

Note: Shaded fields are required fields and MUST be completed for your Application to be processed.

Brief Description of Portability Feature

Subject to the terms of the Group Policy (as described in the Certificate of Coverage), the employee may apply for portability of their Group Term Life Insurance coverage. The Request for Portability of Group Term Life Insurance and payment of the first premium (the payment should not be for more than the Guaranteed Standard Issue amount) for the frequency chosen must be made within 31 days of the date the Group Term Life Insurance terminates, and the employee must not be both disabled and away from work on that date. If the employee is eligible to apply for more than the Guaranteed Standard Issue amount, Aetna will require evidence of the person's good health. If evidence of good health is required, Aetna will send the person, under separate cover, an Evidence of Insurability form which the person must return to Aetna within 31 days of the date it is sent to the person. If the person's evidence statement is approved, Aetna will bill separately for the additional coverage. Premiums must be paid annually, semi-annually, or quarterly by direct bill (nominal per bill fee).

Notice of Eligibility Statement - To be Completed by the Employer (Please Print)

1. Employer Name	2. Group Policy (Control) Number	3. Division Name (If Applicable)
4. Employee Name (First, Middle Initial, Last)	5. Employee Address	
6. Employee Home Telephone Number () () () () () ()		
7. Employee Social Security Number □ □ □ - □ □ - □ □ □ □	8. Was employee actively at work (i.e., not disabled and away from work due to illness or injury) on date of termination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	8a. Was termination due to retirement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	8b. Was the employee insured for dependent life at termination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Coverage Termination Date Month ____ Day ____ Year ____	10. Amount of Basic Life Coverage \$ _____	11. Annual Salary at Time of Termination \$ _____
	10a. Amount of Supplemental Life Coverage \$ _____	
	10b. Amount of Dependent Life Insurance \$ _____ Spouse \$ _____ Child	
12. Was group plan a salary multiple schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", provide the following information: a. Show salary schedule, i.e., 1X, 2X, 3X salary, etc. _____ _____		13. Was insurance offered in "flat" amounts (\$20,000, \$25,000, \$35,000, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes": a. Provide "flat" amount schedule: _____ _____
b. Employee Selected Salary Multiple at Time of Termination _____		
c. Was salary multiple rounded? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate rounded amount \$ _____		b. "Flat" amount selected by employee \$ _____
14. List Employee Most Recent Beneficiary Designation(s)		
Name (First, Middle Initial, Last)	Social Security Number	Birthdate (MM/DD/YYYY) Relationship to Employee
a. Primary _____	□ □ □ - □ □ - □ □ □ □	_____
b. Contingent _____	□ □ □ - □ □ - □ □ □ □	_____
15. If term life insurance has been assigned, provide name, address and Social Security Number of assignee.		
16. For dependent coverage, provide dependent names, relationship to the employee, amounts of coverage and Social Security Numbers.		
17. Check other current benefit provisions employee has. <input type="checkbox"/> Life Disability Benefit (Waiver of Premium) <input type="checkbox"/> Accidental Death Amount \$ _____ <input type="checkbox"/> Accidental Death & Dismemberment Amount \$ _____ <input type="checkbox"/> Other _____		
Signature (Employer Authorized Representative) X		
Date	Phone	Email Address

Aetna Home Office Use Only

Date Portability Request Sent to Applicant	By CSR	Date Received	By CSR
Remarks			

Privacy Notice

In evaluating your insurability, we rely primarily on the health information you furnish to us in this statement.

Disclosure of Information

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction, amendment or deletion of recorded personal information in states which provide such right and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Group Insurance
151 Farmington Avenue
Hartford, CT 06156-7350

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas, Louisiana, Rhode Island, and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents, the following statement applies only to your AD&D coverage:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.