EQUITABLE

Group Employee Benefits

Portability of Accident, Critical Illness/Specified Disease, and/or Hospital Indemnity

Employee, Spouse and Child(ren)

Regular/Express Mail:
Equitable Financial Life Insurance Company/
Equitable Financial Life Insurance Company of America
8501 IMB Dr. Ste 150-B
Charlotte NC, 28262

For assistance call (866) 274-9887

Employer use section: to be completed by the employer

Name of Employer:_____ Policy #: _____

Name of Employee:_____ Class:_____

Critical illness coverage amount eligible to port: Employee $_____ Spouse $_____ Child $_____

Accident coverage eligible to port: ☐ Employee ☐ Spouse ☐ Child(ren)

Hospital indemnity coverage eligible to port: ☐ Employee ☐ Spouse ☐ Child(ren)

Reason for termination of group insurance:

☐ Termination of employment ☐ Disability ☐ Other: _____

☐ Cancellation of group contract ☐ Retirement

Date notice provided:_____ *Month/Day/Year* Coverage termination date:_____ *Month/Day/Year* Employment termination date: _____ *Month/Day/Year*

Employer Signature:_____ Date: _____ *Month/Day/Year*

NOTE TO EMPLOYER: ***Be sure to check the group policy regarding portability limitations and assignments. Notice must be provided to the owner of this coverage. The owner may be other than the employee or dependent.***

1. Employee information

Home address: _____

City_____ State_____ Zip _____

Daytime phone:_____ Evening phone:_____ SS #:_____ Birthday:_____ *Month/Day/Year*

If you wish to continue your supplemental/voluntary coverage, please make election(s) below:

For critical illness, port these amounts:

Employee_____ Spouse_____ Child(ren) _____

For accident, select coverage to be ported:

Employee_____ Spouse_____ Child(ren) _____

For hospital indemnity, select coverage to be ported:

Employee_____ Spouse_____ Child(ren) _____

4. Beneficiary Information

For Accident coverage, 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 (Employee Coverage)	**Percentage**	**Social Security #**	**Date of birth** *Month/Day/Year*	**Relationship**

Beneficiary (Spouse coverage)	**Percentage**	**Social Security #**	**Date of birth** *Month/Day/Year*	**Relationship**

Beneficiary (Children coverage)	**Percentage**	**Social Security #**	**Date of birth** *Month/Day/Year*	**Relationship**

5. Signature

Employee Signature:_____ Date: _____
Month/Day/Year

Complete this section only if the owner is other than the Employee

Owner – The owner is the person who has the right to assign, surrender and exercise all other rights contained in the ported certificate. All correspondence and premium notices will be mailed to the owner and/or provided to the owner electronically as applicable.

Name of owner:_____ Tax I.D./Social Security #: _____

Street address: _____

City_____ State_____ Zip _____

Owner's Signature:_____ Date: _____
(Must be signed by Owner if other than employee) *Month/Day/Year*

6. General information

1. **Rates –** Please note that rates are subject to change. If you would like an estimated premium before applying for coverage, please call (866) 274-9887.
2. **Deadline –** You have 31 days from Coverage Termination Date to exercise the portability option.
3. **Billing** – Please provide a 3-month premium payment with the submission of this form. After your application is processed, you will be billed on a monthly basis. After the initial bill, you will receive your bill approximately 15 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly. Make all check payments payable to:
   Non-NY residents: **Equitable Financial Life Insurance Company of America** *or* **Equitable America**
   NY residents: **Equitable Financial Life Insurance Company** *or* **Equitable Financial**
4. **Coverage terminations and reductions** – Any age-related reductions in insurance continue to apply. You will need to contact us at the address shown on the first page when a child is no longer eligible for coverage (refer to your certificate for additional information). Please contact Equitable at the address shown on the first page of this form and we will provide you with the appropriate forms. At any time that you wish to cancel coverage for yourself, your spouse, and/or children, please call Equitable for instructions.
5. Complete this form, sign and date, and return to **Equitable Employee Benefits Group** at the address shown on page 1. For questions, please call Equitable at (866) 274- 9887.