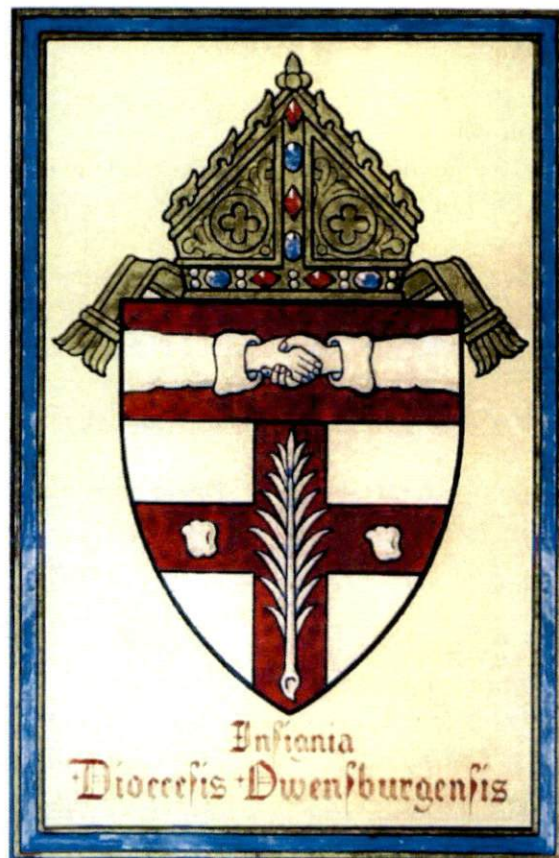


McRaith Catholic Center



Exit Packet



DIOCESE OF OWENSBORO

Employee Exit Checklist

On the Date of the Employee's Notice:

- ✓ If an employee tells you of their intentions to leave, ask them to write a resignation letter, which should be filed in the employees' personnel file. Their letter should contain the last day they intend to work.
- ✓ Next you should notify the Pastor or employer that the employee has made their intentions to leave employment.
- ✓ The network administrator should be notified of the date the employee will no longer be working for the Parish or Diocese, so computer access can be deleted on the appropriate day.
- ✓ Within a day or so of the employees' resignation notice, make sure to give Full Time employees the following paperwork (if applicable): the Retirement change form, the 403 (B) change form, the UNUM Life insurance application and the Health Insurance Self-Pay Notification and Election papers. Also give them a copy of the exit interview form to complete before their last day. This will allow the employee time to review all their benefit options prior to their last day.
- ✓ Direct them to the Diocese's Human Resource Department at 270-683-1545 with any specific questions about their retirement or benefits.

On the Employee's Last Day:

- ✓ Obtain all Parish and Diocese property
- ✓ Obtain necessary passwords to access computer files
- ✓ Obtain the employees retirement and 403 (B) change form, if applicable
- ✓ Review with them to mail their Self Pay Election letter to BAS, Inc.
- ✓ Review status of vacation balance
- ✓ Review the last payroll check date with the employee and the days which will be included on their last check
- ✓ Review with the employee that they must contact the Parish or Diocese, if their address changes in the future, so current year tax forms etc. can be mailed to correct address.
- ✓ For Full Time Employees - Parish or school must send in Benefit Change Form to BAS, and Retirement Papers to Christian Brothers
- ✓ For Full Time Employees – Parish or school should give employees the UMUM Life Insurance conversion application. Employees can call UNUM at 1-800-421-0344 with any question but they must apply within 31 days.

Diocese of Owensboro

Employee Health and Retirement Paperwork for employees leaving employment

Benefit Change Form:

This form should be completed and can be emailed/scanned/mailed/faxed to BAS for all full time employees who leave employment at your location. By completing this form it will first remove the employee from the Life insurance and Long Term Disability plans that are billed monthly to your location from BAS. Also if that employee participates in the health plan this form will remove them from the health insurance and they will no longer be reflected on the BAS monthly bill. Indicate on the top of the form the employee's demographic information with the location's name/ location # and mark "Enrollment Change."

If the employee is enrolled in the health plan their coverage through the Diocese terminates on the last day of the month in which the employee terminates their employment. For example if their last day worked is March 5th, then their health coverage would end March 31st. The Life Insurance and Long Term Disability coverage terminates on the employee's last day worked. However if the employee wants to convert their Life Insurance they can complete the UNUM application within 31 days of termination. They can call UNUM with questions at 1-800-421-0344. The UNUM application is included the Employee Exit packet.

If an employee participates in the health plan they must be given the Self-Pay Privilege Notification Letter and Self-Pay Election Form as a part of their employee exit paperwork. It is the employee's choice to exercise the option to continue to carry health coverage and pay the total premium for health insurance. Employees can keep the coverage for up to 18 months or in the case of early retirement until they are eligible for Medicare. Should an employee be retiring and they have Medicare coverage they can no longer keep the Diocese's health insurance.

Self-Pay Privilege Letter: Enter current date, employee's name, employee's complete address, social security number and salutation with employee's name. **First paragraph of letter** - Your current level of health/dental insurance sponsored by the Diocese of Owensboro will be terminated as of (**enter last day of the month in which coverage ends**) due to **resignation, retirement, etc.** on (**enter last day worked or the day of the qualifying event**).

Continuation of Health Care Coverage Election Form: Item #2 – You first payment will be for the period beginning on (**enter the first day of the month following the coverage term date**) through the end of the month in which you submit your payment. Subsequent monthly payments are due on the first day of each month. The employee must complete the bottom portion of the election form. They must enter the termination date of their health coverage. Then the employee must indicate

the coverage they are currently participating in and the total premium for that coverage. Note this amount is different from the amount employee is currently paying; it is the total premium for the coverage.

Christian Brothers – ERP notice of change/new participant enrollment:

This form is to be completed by the location. Enter the location #, location name and city/state information at the top of the form. **Section 1** – Complete the Employee Demographic Data. **Section 2** – Indicate the Date of Hire and mark the box indicating the employee is full time. **Section 3** – Enter the appropriate code from the list provided, the effective date would be the last day worked and the last pension report date is the last month/year in which the employee will receive pay. For example if they last day worked is May 31st but the employee is paid through July 31st, then you would enter 07/XX. Make sure to sign, date, indicate your title and phone # at the bottom of the form. The completed form can be emailed to rpscustomerservice@cbservices.org. or mailed to Christian Brothers Retirement Services , 1205 Windham Parkway, Romeville, IL 60446-1679 or faxed to 630-378-2507.

Christian Brothers – Notice of Change – For employees participating in the 403b Plan only:

This form is to be completed by the location for those employees participating in the 403b plan only. **Section 1** – Complete the Employee Demographic Data. **Section 2** – Enter the appropriate code from the list provided, the effective date would be the last day worked and enter the date of the final paycheck. Make sure to sign, date, indicate your title and phone # at the bottom of the form. The completed form can be emailed to rpscustomerservice@cbservices.org. or mailed to Christian Brothers Retirement Services , 1205 Windham Parkway, Romeville, IL 60446-1679 or faxed to 630-378-2507.

These forms should be mailed as soon as possible to avoid any delays in coverage or benefits. The employee can contact the Diocese's HR department at 270-683-1545 with any questions.



**Roman Catholic Diocese of Owensboro
Health Benefit Plan**

Self-Pay Privilege Notification Letter

Date: _____
Participant Name: _____
Address: _____

Social Security No.: _____

Dear _____:

Your current level of health/dental insurance sponsored by the Diocese of Owensboro will be terminated as of _____ due to _____ on _____. You are entitled, by a continuation provision of the insurance plan, to continue the current level of health/dental coverage in which you are currently enrolled for up to eighteen months or in the case of early retirement until you become eligible for Medicare. In order to maintain continuation coverage under the plan the following conditions must be met:

1. You must elect to continue coverage within 60 days from the date of this letter.
2. You must make your monthly payments in a timely manner.
3. Those under your current level of health/dental are not covered by any other health plan or entitled to Medicare benefits, provided that the other coverage does not contain an exclusion or limitation due to pre-existing limitations

You may be able to extend your continuation coverage from 18 to 29 months, if the Social Security Administration has determined (or determines) that you have been deemed totally disabled prior to or at any time during the first 60 days of continuation coverage. (You must submit a copy of the Social Security disability determination notice within 60 days of receiving the notice and before the end of the initial 19 months of continuation.)

The enclosed election form must be received by BAS, Inc. within 60 days of the date of this letter. Your first payment is due 45 days after you send in your election form and must include payment back to the loss of coverage date. Then all subsequent payments are due on the first of the month and the payment cannot be postmarked more than 30 days from the due date to be accepted. If your first payment, or any subsequent payment, is not received within this time frame, your continuation rights will be terminated. Coverage is provided only when the full payment for the applicable period is received. Please refer to the enclosed election form for the monthly premium amount due to continuation.

If you have any questions, please call the Diocese of Owensboro's Human Resources department.

Sincerely,

Enclosure



Diocese of Owensboro
Self-Pay Privilege
Continuation of Health Care Coverage Election Form

Important:

If you wish to continue your health coverage, BAS, Inc. must receive:

1. A completed copy of this election form within 60 days of the date of our initial notice to you;

AND

2. Your first payment 45 days following the date you return this election form.
Your first payment will be for the period beginning on _____ through the end of the month in which you submit your payment. Subsequent monthly payments are due on the first day of each month.

Coverage is provided only when the full payment for the applicable period is received.

Employee completes the following information:

I wish to continue coverage under the Roman Catholic Diocese of Owensboro as follows: (each individual from whom coverage is to be continued must have been covered under the Roman Catholic Diocese of Owensboro's health plan on _____, immediately before the qualifying event.):

Check one:

1. Single coverage (current monthly premium is \$_____).
2. Family coverage (current monthly premium is \$_____).

Signature: _____

Date: _____

Print Name: _____

SSN#: _____

Return this completed and signed form to: BAS, Inc.
P.O. Box 896
Bluefield, WV 24701

BAS, Inc. will bill you directly for premiums. **Your payment should be made out to the Roman Catholic Diocese of Owensboro Health Plan** and mailed to: BAS, Inc.
P.O. Box 896
Bluefield, WV 24701



DIocese of OWENSBORO
Benefits Enrollment Form

Loc. Name: _____
Loc. Number: _____



Employee Information (please print clearly):

Social Security Number: _____ - _____ - _____

Date of Hire: ____/____/____

Name: _____
(First) (Middle) (Last)

Date of Birth: ____/____/____

Male: Female:

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____

I. Medical and Dental Insurance

Enrollment in the Section 125 Plan allows eligible employees to reduce their taxable income by withholding certain qualifying benefit premiums before taxes. Medical, dental and prescription coverage begins on the first day of the first full month after the date of hire. Employees will receive an Anthem card for medical/dental benefits and a second card from Caremark for Prescription Coverage.

Check one of the following:

I elect to participate in the Section 125 Health Plan and I authorize the Diocese of Owensboro to make deductions from my paycheck necessary to cover the premiums for the coverage which I have elected and which requires my contribution under the Section 125 Plan. I understand that I cannot change my election unless I have a qualifying event per Section 125 of the IRS Code. _____. (please initial)

I decline Medical and Dental coverage in the Health Plan _____. (please initial) If declining coverage please go to the second page and sign and date the form.

III. Check the Appropriate Boxes

<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family	<input type="checkbox"/> New Hire <input type="checkbox"/> Change of Enrollment Status	Reason for change in status: <input type="checkbox"/> Termination <input type="checkbox"/> Other Insurance <input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Newborn Child <input type="checkbox"/> Divorce <input type="checkbox"/> Last Name/Address Change <input type="checkbox"/> Adoption/Legal Custody of Child <input type="checkbox"/> Legal Custody of Parent <input type="checkbox"/> Dependent Child Married/Reached Age Limit <input type="checkbox"/> Loss of Health Insurance
<input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$2,000 Deductible	<input type="checkbox"/> Open Enrollment	



DIOCESE OF OWENSBORO
Benefits Enrollment Form

Loc. Name: _____
Loc. Number: _____



Mutual of Omaha



IV. List All Eligible Family Members Below (if electing dependent coverage):

First Name	Last Name	DOB	SSN	Sex
Spouse: _____	_____	___/___/___	____-____-____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child _____	_____	___/___/___	____-____-____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child: _____	_____	___/___/___	____-____-____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child: _____	_____	___/___/___	____-____-____	<input type="checkbox"/> M/ <input type="checkbox"/> F
Child: _____	_____	___/___/___	____-____-____	<input type="checkbox"/> M/ <input type="checkbox"/> F

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize any doctor, hospital, insurance company, employer or organization to release any information regarding history, treatment, disability, or benefits for claims to Roman Catholic Bishop of Owensboro Employee Benefit Plan. A copy of this authorization shall be valid as the original.

I UNDERSTAND THE FOLLOWING: This form will be used for benefit information and as a claim form. The information listed is correct and true. To verify incorrect information for this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution to the cost of the benefits I have selected. If I am declining enrollment for myself or my family because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after that event. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after the event.

Do you have other Medical Insurance or Medicare coverage? Yes No

If yes, name of plan/carrier and effective date of coverage: _____

I work 20 hours or more per week: Yes* No

***Employees working 20 hours or more per work week have the following benefits: Medical and Dental Insurance, Basic Life Insurance, Long Term Disability, Accidental Death and Dismemberment (AD&D), Retirement Benefits, and a 403(B) Retirement Savings Plan (see Christian Brothers Retirement Forms). The Benefit Enrollment form will enroll employees in the employer paid Basic Life Insurance, Long Term Disability and AD&D.**

Please return this form to the person responsible for collecting the health insurance enrollment forms at your location.

Employee Signature: _____ Date: ___/___/___



DIOCESE OF OWENSBORO
Benefits Enrollment Form

Loc. Name: _____
Loc. Number: _____



Enter code that applies: _____

This page for EMPLOYER USE only:

Check the box(es) that apply:

1. New employee ____/____/____ (First day of active employment.) Start coverage date: ____/____/____

2. Enrollment change ____/____/____ (Date change takes effect.) Qualifying Event: _____

3. Name/address change Dependent change Effective Date: ____/____/____

4. Termination Date: ____/____/____ Last coverage date: ____/____/____

5. Retirement Date: ____/____/____ Last coverage date: ____/____/____

6. Location transfer From location # _____ to # _____ Effective Date: ____/____/____

Class:

Lay Religious Priest Medicare coverage: Primary Secondary

No. hours worked each week: _____ Occupation/Title: _____

Earnings:

Annual amount \$ _____ (Determines lay employee's Life and LTD benefits.)

Employer Signature: _____ Title: _____

Date Signed: ____/____/____ Phone #: (____) _____ - _____

- 1) Send copy to BAS, Inc., P. O. Box 896, Bluefield WV 24701
- 2) Keep copy in employee file
- 3) Send copy to -Diocese of Owensboro, ATTN: Mary Hall, 600 Locust St, Owensboro, KY 42301



**ROMAN CATHOLIC
DIOCESE OF OWENSBORO**
EMPLOYEE BENEFIT PLAN

Rates effective September 1, 2014 to August 31, 2015

	\$500 Deductible Monthly Rates	\$2,000 Deductible Monthly Rates
Single coverage		
Total Premium	618.82	531.56
EmployER pays	412.50	412.50
EmployEE pays	176.32	89.06
Benefit PLAN pays	30.00	30.00
Employee & Family		
Total Premium	1,399.78	1,202.41
EmployER pays	412.50	412.50
EmployEE pays	644.89	546.20
Benefit PLAN pays	342.39	243.71

VISON RATES	Monthly Rates
Employee	7.35
Employee+ Spouse	12.85
Employee + Children	13.95
Family	21.3

ERP NOTICE OF CHANGE/NEW PARTICIPANT ENROLLMENT

(To Be Completed By Employer)

Return this form to:

Christian Brothers Retirement Services
1205 Windham Parkway
Romeoville, IL 60446-1679
Fax: 630-378-2507
E-mail: rpscustomerservice@cbservices.org

Location No. _____

Employer Name: _____

City/State: _____

Zip Code: _____

Section 1 - Employee Data

Employee Last Name: _____

First Name: _____

Middle: _____

Street Address: (check if new) _____

City/State: _____

Zip Code: _____

Soc. Sec. No.: _____

Date of Birth: _____

Sex: M F

Marital Status: (Circle One)

Single Married Widowed Divorced

Spouse's Name : _____

Spouse's DOB: _____

Spouse's SS#: _____

Section 2 - New Employee Eligibility

Date of Hire: _____

Part-Time (Check one)
(Less than 20 hrs)

Full-Time
(20 hrs or more)

Probationary Period: Yes No If Yes # of months: 1 3 6 9 1 yr (circle one)

Date Eligible to Participate (20 hours or more): ____/____/____
(Mo) (day) (year)

Section 3 - Change of Status After Enrollment

Enter Code No.
(select from descriptions below):

Effective Date:
(last date worked) ____/____/____
(mo) (day) (year)

Last Pension Report to appear on: (MM/YY)

Code No:

Code Description:

- 1 Termination From Plan
- 2 Address Name Change (check applicable item)
- 3 Death
- 4 Retirement
- 5 Leave of Absence (Without Pay)
- 6 Return from Leave of Absence
- 7 Disability
- 8 Transfer
- 9 Rehire
- 10 Other (please specify): _____

Employer Signature: _____ Date Signed: _____

Title: _____ /Phone #: _____

FORM MUST BE SIGNED BY EMPLOYER



NOTICE OF CHANGE (093264)

Location No. _____

Christian Brothers Retirement Savings Plan
1205 Windham Parkway
Romeoville, IL 60446

Return This Form To:

SECTION I: EMPLOYEE DATA

Name of Employer: _____ City/State _____

Employee Last Name _____ First _____ Middle _____

Street Address _____

City _____ State _____ Zip _____ Soc. Sec. No. _____

SECTION II: AFTER ENROLLMENT CHANGES

CODE DESCRIPTION

- (1) Employment Ended
- (2) Address Change
- (3) Name Change
- (4) Death
- (5) Retirement
- (6) Disability
- (7) Hardship
- (8) Plan Termination
- (9) Other (specify)

CODE	DATE EFFECTIVE
DATE OF FINAL PAYCHECK	

Date Signed _____ Signature of Employer or Plan Sponsor _____

Position _____

UNUM Life Insurance

Give Life Insurance Application to all Full Time Employees.

They can call UNUM at 1-800-421-0344 but must apply within thirty-one days of last day worked.



LIFE INSURANCE
NOTIFICATION OF CONVERSION PRIVILEGE
Unum Life Insurance Company of America (Unum)

1. **Conversion rights** – When your group life insurance terminates or the amount of coverage you have is reduced, you can convert your coverage to an individual Whole Life Policy or you may purchase a Single Premium Convertible One-Year Term Life Policy. You may purchase either of these options without having to provide evidence of insurability.
2. **Start Conversion within 31 days** – Your life insurance coverage under your employer's group policy remains in effect for 31 days after the date of termination or reduction of coverage. You may apply for conversion any time within that period.

If you do not apply within 31 days, the option to convert will no longer be available to you.

How to apply for Conversion

If you wish to convert your group life insurance coverage to an individual policy, complete the attached application and send it with your first premium payment (made payable to Unum) to:

Unum
Portability and Conversion Unit
2211 Congress St.
Portland, Maine 04122

3. **Amount of coverage you can buy** – When your group coverage terminates or reduces, you can apply for any amount of life insurance up to, but not exceeding the amount you had under your group plan.
4. **Cost of an individual policy** – The rates included in this package show the cost of an individual policy. If your rate is not listed, please call Unum at 1-800-421-0344.

COMPLETING THE APPLICATION

1. **Employer completes this section** – Employer must complete the top section of the application before giving to the employee.
2. **Employee completes this section** – Employee must complete this section in order to continue this coverage.
 - a. **Print Insured's Name** – Enter full name, check male or female and enter date of birth.
 - b. **Applicants / Dependent's Name (if other than insured)** – Enter the name of the person applying for insurance if it is other than the insured person. Check male or female and enter date of birth.
 - c. **Insured's Address** – Enter full mailing address of the insured.
3. **What type of insurance are you electing?** You may elect Individual Whole Life or a Single Premium Convertible One-Year Term Life Policy. If you elect the Single Premium Convertible Policy, your Whole Life Insurance Policy will become effective after one year provided the premium due is received within the lifetime of the insured and within the Grace Period as provided in your Whole Life Policy.
4. **What is the amount of insurance you wish to convert** – Enter the exact amount of life insurance you wish to convert to an individual policy. Please note that you may not convert an amount in excess of the amount of coverage you held under the group policy.
5. **Check premium payment mode** – Check the box next to the mode of payment that you elect to pay your premiums.
6. **Do you wish to elect Automatic Premium Loan** – You are entitled to have any loan value on the policy automatically used to pay any premium which is unpaid on expiration of the 31 day grace period.
7. **Whom do you wish as beneficiary(ies) under the Individual Policy** – Enter the full name and relationship of your Primary and Contingent beneficiaries.

8. Signatures –

Insured's Signature – The person whose life is being covered for insurance must sign the application unless he/she is under 18 years of age.

Applicant's Signature – If the insured is under 18 years of age, the parent or guardian who will be paying the insurance premiums must sign here.

Witness Signature – Any person other than the insured must sign as a witness to the application.

Special Instructions for Completing the Application

- A separate application must be completed for each applicant applying for coverage.
- Any changes made to your answers must be initialed and dated.



APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE TO AN INDIVIDUAL LIFE INSURANCE POLICY
 Unum Life Insurance Company of America

1. Employer Completes this Section

Company Name		Group Policy and Division Numbers	
Employee's Name (Last, First, MI)		Social Security Number	Date of Birth
Dependent Name (if converting dependent coverage)		Social Security Number	Date of Birth
Group life insurance benefits were: <input type="checkbox"/> Terminated <input type="checkbox"/> Reduced	Reason for Termination	Date of Termination or Reduction	Amount of Coverage Lost \$
Was the employee disabled on date of termination or reduction? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Disability (Date last worked)	
If yes, see (waiver of premium) Extension of Employee Life Insurance Provision of the group contract, if available under the group plan.			
Has Employee submitted a claim for extension of group benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the group life coverage previously assigned? (collateral/absolute) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Signature			Date

2. Employee Information

A. Print Insured's Name (Last, First, Mid. Int.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
B. Applicant's/Dependent's Name (if other than insured)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
C. Insured's Address (No. & Street, City, State, Zip Code and Phone Number)		

3. I elect the following life insurance:
 Whole Life Only Single Premium Convertible One-Year Term Life with automatic conversion to Whole Life
Note: The individual policy that you convert to will not contain waiver of premium or accidental death benefits.

4. What is the amount of insurance you wish to convert? \$ _____
Note: The amount may not exceed the amount shown in section 1.

5. Check premium payment mode <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly	6. Do you wish to elect automatic premium loan? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

7. Whom do you wish as beneficiary(ies) of proceeds under the individual policy?
 Primary: _____
 If beneficiary(ies) named above not living, then pay:
 Contingent: _____

I UNDERSTAND AND AGREE THAT: (1) The statements and answers in the above application are true, complete and correctly recorded to the best of my knowledge and belief. (2) Any policy issued on this application will be issued in accordance with the conversion privilege contained in the Group Policy. (3) The policy will become effective on the day following the last day of the conversion period prescribed under the Group Policy. (4) The beneficiary designation above has no effect on the beneficiary designation for any death benefits payable under the Group Policy. (5) If any death benefit paid under the Group Policy includes an amount representing the coverage shown in item 4 above, the individual policy will be void from the beginning. In this case, we, Unum Life Insurance Company of America, will refund to the beneficiary any premium paid. **See reverse side for fraud notices.**

8. Insured's Signature	Date	Applicant's/Dependent's Signature	Date	Witness Signature (if other than insured)	Date
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Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

FRAUD NOTICE

For Residents of Maine, Tennessee and Washington: 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.

For Residents of Florida: 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.

For Residents of Kansas: Any person who knowingly and with intent to defraud presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Kentucky, Ohio and Pennsylvania: 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.

For Residents of Minnesota: Any person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

For Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For Residents of New Mexico: 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 civil fines and criminal penalties.

For Residents of Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For Residents of the District of Columbia: 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.

For Residents of All Other States: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

Conversion Rates

Age	Annual Rate 1-Year Term	Rates for Individual Whole Life			Age	Annual Rate 1-Year Term	Rates for Individual Whole Life		
		Annual	Semiannual	Quarterly			Annual	Semiannual	Quarterly
0	5.05	2.06	1.07	0.57	46	8.92	22.08	11.48	6.07
1	5.05	2.16	1.12	0.59	47	9.66	22.62	11.76	6.22
2	5.05	2.27	1.18	0.62	48	10.41	23.44	12.19	6.45
3	5.05	2.39	1.24	0.66	49	11.15	24.52	12.75	6.74
4	5.05	2.51	1.31	0.69	50	11.89	25.87	13.45	7.11
5	5.05	2.63	1.37	0.72	51	13.47	27.95	14.53	7.69
6	5.05	2.77	1.44	0.76	52	15.05	29.88	15.54	8.22
7	5.05	2.91	1.51	0.80	53	16.62	32.08	16.68	8.82
8	5.05	3.05	1.59	0.84	54	18.20	34.56	17.97	9.50
9	5.05	3.21	1.67	0.88	55	19.78	38.69	20.12	10.64
10	5.05	3.37	1.75	0.93	56	21.73	39.23	20.40	10.79
11	5.05	3.54	1.84	0.97	57	23.69	40.31	20.96	11.09
12	5.05	3.72	1.93	1.02	58	25.64	41.94	21.81	11.53
13	5.05	3.91	2.03	1.08	59	27.60	44.10	22.93	12.13
14	5.05	4.11	2.14	1.13	60	29.55	46.81	24.34	12.87
15	5.05	5.29	2.75	1.45	61	32.82	51.32	26.69	14.11
16	5.10	5.56	2.89	1.53	62	36.08	55.21	28.71	15.18
17	5.15	5.83	3.03	1.60	63	39.35	59.65	31.02	16.40
18	5.29	6.10	3.17	1.68	64	42.61	64.64	33.61	17.78
19	5.43	6.36	3.31	1.75	65	45.88	72.96	37.94	20.06
20	5.74	6.99	3.63	1.92	66	49.74	76.31	39.68	20.99
21	5.49	7.27	3.78	2.00	67	53.61	79.66	41.42	21.91
22	5.24	7.55	3.93	2.08	68	57.47	83.01	43.17	22.83
23	5.00	7.84	4.08	2.16	69	61.34	86.36	44.91	23.75
24	4.75	8.12	4.22	2.23	70	65.20	93.06	48.39	25.59
25	4.50	8.40	4.37	2.31	71	73.41	105.19	54.70	28.93
26	4.35	8.65	4.50	2.38	72	81.63	112.26	58.38	30.87
27	4.20	8.90	4.63	2.45	73	89.84	119.32	62.05	32.81
28	4.06	9.15	4.76	2.52	74	98.06	126.38	65.72	34.75
29	3.91	9.40	4.89	2.59	75	106.27	147.58	76.74	40.58
30	3.76	9.65	5.02	2.65	76	114.77	156.43	81.34	43.02
31	3.82	11.55	6.01	3.18	77	123.95	165.82	86.23	45.60
32	3.88	11.84	6.16	3.26	78	133.87	175.77	91.40	48.34
33	3.94	12.13	6.31	3.34	79	144.58	186.31	96.88	51.24
34	4.00	12.42	6.46	3.42	80	156.15	197.49	102.69	54.31
35	4.06	12.85	6.68	3.53	81	168.64	209.34	108.86	57.57
36	4.30	12.98	6.75	3.57	82	182.13	221.90	115.39	61.02
37	4.53	13.25	6.89	3.64	83	196.70	235.22	122.31	64.69
38	4.77	13.64	7.09	3.75	84	212.43	249.33	129.65	68.57
39	5.00	14.16	7.36	3.89	85	229.43	264.29	137.43	72.68
40	5.24	15.61	8.12	4.29	86	247.78	280.15	145.68	77.04
41	5.83	16.43	8.54	4.52	87	260.17	296.95	154.41	81.66
42	6.42	17.40	9.05	4.79	88	273.18	314.77	163.68	86.56
43	7.00	18.50	9.62	5.09	89	286.84	333.66	173.50	91.76
44	7.59	19.74	10.26	5.43	90	301.18	353.68	183.91	97.26
45	8.18	21.81	11.34	6.00					

Policy Fee is as follows:

\$90.00 per annual payment

\$46.80 per semi annual payment

\$24.75 per quarterly payment

Please note: Rates are per \$1,000 of coverage

How to Calculate Your Premium Payment

<u>Calculate Your Premium Payment</u>	<u>Check Your Elections Below</u>
1. Determine if you want the whole life or the 1-Year Term coverage. The 1-Year Term will be renewed next year at your attained age to Whole Life coverage assuming premiums are paid in full. If you elect the 1-Year Term, you must submit an annual premium payment. Note that the 1-Year Term coverage is not available in all states.	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">Whole Life <input type="checkbox"/></div> <div style="text-align: center;">1-Year Term <input type="checkbox"/></div> </div>
2. If you have selected whole life, determine whether you want to pay your whole life premiums annually, semi-annually, or quarterly.	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">Annual <input type="checkbox"/></div> <div style="text-align: center;">Semi-Annual <input type="checkbox"/></div> <div style="text-align: center;">Quarterly <input type="checkbox"/></div> </div>
3. Find your rate on the rate table. The rate is based on the type of coverage you want and your age at the time your conversion coverage begins, which is 31 days from the time your group coverage terminates or is reduced.	Base Rate per \$1,000 of Coverage _____
4. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.	Amount of Coverage _____
5.	<u>Calculate Your Premiums</u>
a. Base rate per thousand dollars of coverage:	Base Rate _____
b. Number of thousand dollar units you want:	# of \$1,000 Units x _____
c. Multiply a. by b.:	Base Rate X # of Units _____
d. If you selected whole life, add the policy fee:	Policy Fee + _____
No policy fee for 1-Year Term	
Annual \$90.00 per payment	
Semi-annual \$46.80 per payment	
Quarterly \$24.75 per payment	
e. TOTAL c. and d. This is your premium.	* TOTAL <u> </u>
Please make your check payable to Unum	* This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding.
<u>Example</u>	
1. A 44 year old person decides to convert to a whole life policy	
2. The person wants to convert \$25,000 of coverage	
3. The person wants to pay premiums semi-annually	
4. The semi-annual rate for a 44 year old is \$10.26 per \$1,000 of insurance	
5. Calculate premiums:	
a. Base rate per thousand dollars of coverage:	\$10.26
b. Number of thousand dollar units you want:	X 25
c. Multiply a. by b.:	\$256.50
d. If you selected whole life, add the policy fee:	
No policy fee for 1-Year Term	\$0.00
Annual \$90.00 per payment	-
Semi-annual \$46.80 per payment	\$46.80
Quarterly \$24.75 per payment	-
e. TOTAL c. and d. This is your premium.	<u> </u> \$303.30

Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.



Important Information When Considering Portability Coverage

When your group term life insurance coverage ends, either because your employment has terminated or you no longer are eligible to participate in your employer's group life policy, you have two choices for continuing your life insurance coverage: Portability or Conversion. While there are a number of differences between portability and conversion, some key considerations are:

- **Portability** allows you and your dependents to continue (or "port") your Life and/or AD&D coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer's group life insurance policy. **Importantly, you cannot port coverage for anyone who has an injury or sickness which has a material effect on life expectancy.**
- **Conversion** allows you and your dependents to purchase individual life insurance policies (but not AD&D) at rates that may be higher than portability rates. The conversion policies you choose will not contain the exact same coverage you had under your employer's group life insurance policy. **Unlike portability, conversion is available even if you or your dependents have a sickness or injury which has a material effect on life expectancy.**

If you believe Portability is right for you, read the information below to determine whether you and your dependents are eligible to port your coverage.

PORTABILITY COVERAGE IS NOT AVAILABLE FOR ANYONE WITH AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. This means individuals diagnosed with, or having received medical advice or sought treatment for, any of the following injuries or sicknesses in the past 10 years cannot elect this coverage:

<ul style="list-style-type: none"> • Acquired immune deficiency syndrome (AIDS) • Amyotrophic lateral sclerosis (ALS) • Cerebral palsy with cognitive impairment • Chronic renal disease • Chronic lung disease, including emphysema • Cirrhosis of the liver • Congestive heart failure • Coronary artery disease, heart surgery, or transient ischemic attack (TIA) • Cystic fibrosis • Dementia, including Alzheimer's disease • Diabetes other than gestational or diet controlled • Drug or alcohol abuse • Hepatitis B or C • High blood pressure concurrently treated with three or more medications 	<ul style="list-style-type: none"> • Leukemia, lymphoma or any cancer other than basal or squamous cell carcinoma of the skin • Morbid obesity defined as a Body Mass Index (BMI) greater than 40 <p><i>Calculate a BMI using the Center for Disease Control's BMI Calculator online at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html or call us with height/weight information and we'll calculate it for you.</i></p> <ul style="list-style-type: none"> • Muscular dystrophy • Psychiatric hospitalization • Quadriplegia • Stroke • Systemic lupus erythematosus or any other rheumatologic disease
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If you are not sure whether anyone applying for this coverage has an injury or sickness in the list above, then attach to this election form the name of the individual with the injury/sickness, his/her relationship to you, a description of the condition, and any current medications. Unum will review the information provided and let you know whether portable coverage is an option.

Important: When a life insurance claim is submitted to Unum on an individual who died within two years of the date that portability coverage became effective, Unum reviews medical records to determine whether the deceased individual was eligible for portability. If Unum determines the deceased individual wasn't eligible for portability due to an injury or sickness which had a material effect on life expectancy, the beneficiary will not receive the portability amount elected. Instead, the beneficiary will receive a significantly reduced benefit (or possibly no benefit at all). Please see the Portability section of your employer's group policy for an explanation of how the benefit may be reduced.

If after reading the information on this page you believe you and/or your dependents aren't eligible to elect portability coverage, remember that you and your dependents may qualify for conversion coverage. Contact your employer for the conversion application form and rates.

If you believe you and/or your dependents are eligible for portability, continue to page 2.

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.
- **Supplemental Life** is insurance elected by you for which you paid the premiums when you were in active employment.
- **AD&D** is Accidental Death & Dismemberment coverage and may not exceed Life coverage.

What are your employer's responsibilities?

- Fully complete Section 1 on page 3 of this election form and provide it to the employee. Incomplete election forms may result in a denial of coverage.
- Provide the portability rate table to the employee.

What are your responsibilities as the employee?

- Complete Section 2 on page 3 and the Beneficiary Designation Form on page 4. Incomplete forms may be denied.
- Portable coverage is available in amounts up to your current coverage amounts without evidence of insurability—but cannot exceed \$750,000 across all Unum Life and AD&D coverages.
- If you wish to elect 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 group life insurance policy.
- An initial premium payment must be submitted with this election form within 31 days from the date your coverage ends.
- Please remember to (1) include the initial premium payment; (2) sign and date page 3 of this election form; (3) designate a beneficiary on page 4; and (4) retain a copy of this entire form for your records.
- Mail pages 3 and 4 of this election form and your initial premium payment to the address listed at the top of page 3.

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.



TERM LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE
 Submit to: Unum Life Insurance Company of America (Unum) Portability Unit
 2211 Congress Street, Portland, ME 04122 • 1-800-421-0344 • Fax 207-575-2993

EMPLOYER COMPLETES SECTION 1

Company Name:		Policy Number	Division	Class
Employee Name (Last, First, MI):		Policy Number	Division	Class
Date Coverage Ends (mm/dd/yyyy): asdADS	Insured on disability or sick leave when terminated? <input type="checkbox"/> Yes* <input type="checkbox"/> No	Reason for Loss of Coverage: <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Retired <input type="checkbox"/> Reduced Hours (must be working) <input type="checkbox"/> Other, Explain		
Current Annual Earnings: \$	*If Yes, date premium paid to:			

Fill in Current Coverage Amounts for Each Insured and Insurance Type

Insured Type	Basic Life	Supplemental Life	Basic AD&D	Supplemental AD&D
Employee				
Spouse				
Child				

Plan Administrator Name:	Plan Administrator Signature:
Plan Administrator Telephone Number:	Plan Administrator Email:

EMPLOYEE COMPLETES SECTION 2

Insured Mailing Address (Street, PO Box, City, State, Zip):		Home Telephone:	
		Alternate Telephone:	
Insured Social Security Number:	Insured Date of Birth (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: *

* Check the policy or your certificate. Dependent eligibility is subject to age, student and/or marriage status.

Have you used tobacco products in the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse used tobacco products in the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Fill in Requested Coverage Amounts for Each Insured and Insurance Type - coverages left blank will result in a coverage amount of \$0. Coverage reduces according to your employer's group insurance policy.

Insured Type	Basic Life	Supplemental Life	Basic AD&D	Supplemental AD&D
Employee				
Spouse				
Child				

Select a premium payment option:
 Quarterly (Every three months) Semi-Annually (Every six months) Annually (One time per year)
Make your check or money order payable to Unum.

I understand and agree to the following:
 Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Unum group term life coverage and/or Accidental Death and Dismemberment insurance coverage under which this coverage is being offered and is subject to satisfaction of the conditions provided therein.

Portable coverage will be effective the first of the month after your group coverage ends subject to your applying for portable coverage for yourself and your dependents and paying the first premium within 31 days after the date your group coverage ends.

HAVING READ AND UNDERSTOOD THE "IMPORTANT INFORMATION WHEN CONSIDERING PORTABILITY COVERAGE" SECTION ON PAGE 1 OF THIS FORM, I CERTIFY THAT NEITHER I NOR MY DEPENDENTS HAVE AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. I UNDERSTAND UNUM IS RELYING ON THIS CERTIFICATION AS A MATERIAL CONDITION TO ITS AGREEMENT TO PROVIDE COVERAGE.

If Unum determines that an injury or sickness has a material effect on life expectancy, as of the date portable coverage was elected, benefits may be reduced to the amount of coverage available under the current policy's conversion privilege.

Insured Signature:	Today's Date (mm/dd/yyyy):	Insured's Email Address
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Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.



PORTABILITY BENEFICIARY DESIGNATION FORM

2211 Congress Street
Portland Maine 04122
Phone: 1-800-421-0344
Fax: 207-575-2993

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). 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	
		[] [] [] - [] [] [] - [] [] [] []	
Policy Number	Division	BL Number	
[] [] [] [] [] []	[] [] [] []	BL [] [] [] [] [] [] [] [] [] []	

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**

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.



**HOW TO CALCULATE YOUR
PORTABILITY PREMIUM PAYMENT**

<p>Calculate Your Premium Payment</p> <p>1. Find your rate on the rate table under appropriate tobacco use, if applicable. The rate is based on your age at the time your coverage terminates or is reduced.</p> <p>Note: You will qualify for non-tobacco premium rates if you have not used any tobacco products within the last 12 months. Your life insurance rates will continue to increase with age, every 5 years (for example, at age 50, 55, 60 etc.).</p>	<p>Base Rate Per \$1,000 of Coverage _____</p>															
<p>2. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.</p> <p>Note: You may be eligible to increase your coverage which would require Evidence of Insurability subject to maximums outlined in your former group insurance policy.</p>	<p>Amount of Coverage _____</p>															
<p>3. a. Base Rate Per thousand dollars of coverage:</p> <p>b. Number of thousand dollars you want:</p> <p>c. Multiply a. by b.:</p> <p>d. Mode you would like to pay</p> <p style="margin-left: 20px;">quarterly = 3</p> <p style="margin-left: 20px;">Semi-annual = 6</p> <p style="margin-left: 20px;">Annual = 12</p> <p>e. TOTAL c. and d. This is your premium</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Base Rate</td> <td style="width: 10%;"></td> <td style="width: 40%;">_____</td> </tr> <tr> <td># of \$1,000 Units</td> <td style="text-align: center;">x</td> <td>_____</td> </tr> <tr> <td>Base Rate X # of Units</td> <td></td> <td>_____</td> </tr> <tr> <td>Mode Numeric</td> <td style="text-align: center;">x</td> <td>_____</td> </tr> <tr> <td colspan="2">*TOTAL</td> <td>_____</td> </tr> </table>	Base Rate		_____	# of \$1,000 Units	x	_____	Base Rate X # of Units		_____	Mode Numeric	x	_____	*TOTAL		_____
Base Rate		_____														
# of \$1,000 Units	x	_____														
Base Rate X # of Units		_____														
Mode Numeric	x	_____														
*TOTAL		_____														
<p>*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding</p>																
<p>Example:</p> <p>1. A 44 year old person decides to continue \$25,000 of coverage</p> <p>2. The person wishes to pay premiums annually</p> <p>3. The monthly rate for a 44 year old is \$.510 per \$1,000 of coverage</p> <p>4. Calculate premiums:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">a. Base rate per thousand dollars of coverage:</td> <td style="width: 20%; text-align: right;">\$.510</td> </tr> <tr> <td>b. Number of thousand dollar units you want:</td> <td style="text-align: right;">x 25</td> </tr> <tr> <td>c. Multiply a. by b.:</td> <td style="text-align: right;">\$12.75 (Monthly)</td> </tr> <tr> <td>d. Multiply c. by 12 for annual</td> <td style="text-align: right;">x 12</td> </tr> <tr> <td>e. TOTAL. This is your premium.</td> <td style="text-align: right;">\$153.00 (Annually)</td> </tr> </table>		a. Base rate per thousand dollars of coverage:	\$.510	b. Number of thousand dollar units you want:	x 25	c. Multiply a. by b.:	\$12.75 (Monthly)	d. Multiply c. by 12 for annual	x 12	e. TOTAL. This is your premium.	\$153.00 (Annually)					
a. Base rate per thousand dollars of coverage:	\$.510															
b. Number of thousand dollar units you want:	x 25															
c. Multiply a. by b.:	\$12.75 (Monthly)															
d. Multiply c. by 12 for annual	x 12															
e. TOTAL. This is your premium.	\$153.00 (Annually)															

Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

**EXIT INTERVIEW FORM
DIOCESE OF OWENSBORO**

The purpose of the exit interview is twofold. First, it is to help determine the reason for the employee's departure and to determine if it would have been possible to keep the employee when appropriate. Second, it is to evaluate the employee's thinking in relationship to us as employer. This will assist us in determining whether we as an employer need to make changes.

1. JOB CONTENT

A. What factors contributed to your accepting a job with the Diocese? Have your feelings changed?

B. Did you understand the job expectations when you were hired?

C. Did you receive sufficient training to meet those expectations?

D. Did you know how or where to get information you needed to succeed at your job?

E. Do you have any suggestions that you feel could assist us in helping our next employee to understand his/her job?

2. DIOCESE AS A PLACE TO WORK

A. Please rate the following aspects of your employment with the Diocese:

	Excellent	Good	Fair	Poor
Opportunity for Advancement				
Performance Appraisals				
Physical Working Conditions				
Your Wages				
Vacation/Sick/Holidays				
Other Company Benefits				
Feeling of Belonging				

B. Were you provided with written personnel policies and adequate documentation on your benefits?

C. What would make you interested in returning to work with the Diocese?

D. Have you been treated fairly?

3. REASONS FOR LEAVING

A. What is your reason for leaving?

B. What could the diocese have done to prevent you from leaving?

C. What part does salary play in your decision to leave?

D. If you are going to another job, what does that job offer you that your job with the Diocese did not?

E. Do you have any suggestions that you feel would make us a better employer?

POSITION: _____

INTERVIEWER: _____ DATE: _____



Important Information When Considering Portability Coverage

When your group term life insurance coverage ends, either because your employment has terminated or you no longer are eligible to participate in your employer’s group life policy, you have two choices for continuing your life insurance coverage: Portability or Conversion. While there are a number of differences between portability and conversion, some key considerations are:

- **Portability** allows you and your dependents to continue (or “port”) your Life and/or AD&D coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer’s group life insurance policy. **Importantly, you cannot port coverage for anyone who has an injury or sickness which has a material effect on life expectancy.**
- **Conversion** allows you and your dependents to purchase individual life insurance policies (but not AD&D) at rates that may be higher than portability rates. The conversion policies you choose will not contain the exact same coverage you had under your employer’s group life insurance policy. **Unlike portability, conversion is available even if you or your dependents have a sickness or injury which has a material effect on life expectancy.**

If you believe Portability is right for you, read the information below to determine whether you and your dependents are eligible to port your coverage.

PORTABILITY COVERAGE IS NOT AVAILABLE FOR ANYONE WITH AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. This means individuals diagnosed with, or having received medical advice or sought treatment for, any of the following injuries or sicknesses in the past 10 years cannot elect this coverage:

<ul style="list-style-type: none"> • Acquired immune deficiency syndrome (AIDS) • Amyotrophic lateral sclerosis (ALS) • Cerebral palsy with cognitive impairment • Chronic renal disease • Chronic lung disease, including emphysema • Cirrhosis of the liver • Congestive heart failure • Coronary artery disease, heart surgery, or transient ischemic attack (TIA) • Cystic fibrosis • Dementia, including Alzheimer’s disease • Diabetes other than gestational or diet controlled • Drug or alcohol abuse • Hepatitis B or C • High blood pressure concurrently treated with three or more medications 	<ul style="list-style-type: none"> • Leukemia, lymphoma or any cancer other than basal or squamous cell carcinoma of the skin • Morbid obesity defined as a Body Mass Index (BMI) greater than 40 <p><i>Calculate a BMI using the Center for Disease Control’s BMI Calculator online at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html or call us with height/weight information and we’ll calculate it for you.</i></p> <ul style="list-style-type: none"> • Muscular dystrophy • Psychiatric hospitalization • Quadriplegia • Stroke • Systemic lupus erythematosus or any other rheumatologic disease
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If you are not sure whether anyone applying for this coverage has an injury or sickness in the list above, then attach to this election form the name of the individual with the injury/sickness, his/her relationship to you, a description of the condition, and any current medications. Unum will review the information provided and let you know whether portable coverage is an option.

Important: When a life insurance claim is submitted to Unum on an individual who died within two years of the date that portability coverage became effective, Unum reviews medical records to determine whether the deceased individual was eligible for portability. If Unum determines the deceased individual wasn’t eligible for portability due to an injury or sickness which had a material effect on life expectancy, the beneficiary will not receive the portability amount elected. Instead, the beneficiary will receive a significantly reduced benefit (or possibly no benefit at all). Please see the Portability section of your employer’s group policy for an explanation of how the benefit may be reduced.

If after reading the information on this page you believe you and/or your dependents aren’t eligible to elect portability coverage, remember that you and your dependents may qualify for conversion coverage. Contact your employer for the conversion application form and rates.

If you believe you and/or your dependents are eligible for portability, continue to page 2.

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.
- **Supplemental Life** is insurance elected by you for which you paid the premiums when you were in active employment.
- **AD&D** is Accidental Death & Dismemberment coverage and may not exceed Life coverage.

What are your employer's responsibilities?

- Fully complete Section 1 on page 3 of this election form and provide it to the employee. Incomplete election forms may result in a denial of coverage.
- Provide the portability rate table to the employee.

What are your responsibilities as the employee?

- Complete Section 2 on page 3 and the Beneficiary Designation Form on page 4. Incomplete forms may be denied.
- Portable coverage is available in amounts up to your current coverage amounts without evidence of insurability—but cannot exceed \$750,000 across all Unum Life and AD&D coverages.
- If you wish to elect 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 group life insurance policy.
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- Please remember to (1) include the initial premium payment; (2) sign and date page 3 of this election form; (3) designate a beneficiary on page 4; and (4) retain a copy of this entire form for your records.
- Mail pages 3 and 4 of this election form and your initial premium payment to the address listed at the top of page 3.

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.



TERM LIFE INSURANCE ELECTION OF PORTABILITY COVERAGE
 Submit to: Unum Life Insurance Company of America (Unum) Portability Unit
 2211 Congress Street, Portland, ME 04122 • 1-800-421-0344 • Fax 207-575-2993

EMPLOYER COMPLETES SECTION 1

Company Name:		Policy Number	Division	Class
		<input type="text"/>	<input type="text"/>	<input type="text"/>
Employee Name (Last, First, MI):		Policy Number	Division	Class
		<input type="text"/>	<input type="text"/>	<input type="text"/>
Date Coverage Ends (mm/dd/yyyy): asdADS	Insured on disability or sick leave when terminated? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If Yes, date premium paid to: _____	Reason for Loss of Coverage: <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Retired <input type="checkbox"/> Reduced Hours (must be working) <input type="checkbox"/> Other, Explain		
Current Annual Earnings: \$ _____				

Fill in Current Coverage Amounts for Each Insured and Insurance Type

Insured Type	Basic Life	Supplemental Life	Basic AD&D	Supplemental AD&D
Employee				
Spouse				
Child				

Plan Administrator Name:	Plan Administrator Signature:
Plan Administrator Telephone Number:	Plan Administrator Email:

EMPLOYEE COMPLETES SECTION 2

Insured Mailing Address (Street, PO Box, City, State, Zip):		Home Telephone:	
		Alternate Telephone:	
Insured Social Security Number:	Insured Date of Birth (mm/dd/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: *

* Check the policy or your certificate. Dependent eligibility is subject to age, student and/or marriage status.

Have you used tobacco products in the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse used tobacco products in the past twelve months? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Fill in Requested Coverage Amounts for Each Insured and Insurance Type - coverages left blank will result in a coverage amount of \$0. Coverage reduces according to your employer's group insurance policy.

Insured Type	Basic Life	Supplemental Life	Basic AD&D	Supplemental AD&D
Employee				
Spouse				
Child				

Select a premium payment option:
 Quarterly (Every three months) Semi-Annually (Every six months) Annually (One time per year)
Make your check or money order payable to Unum.

I understand and agree to the following:
 Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Unum group term life coverage and/or Accidental Death and Dismemberment insurance coverage under which this coverage is being offered and is subject to satisfaction of the conditions provided therein.

Portable coverage will be effective the first of the month after your group coverage ends subject to your applying for portable coverage for yourself and your dependents and paying the first premium within 31 days after the date your group coverage ends.

HAVING READ AND UNDERSTOOD THE "IMPORTANT INFORMATION WHEN CONSIDERING PORTABILITY COVERAGE" SECTION ON PAGE 1 OF THIS FORM, I CERTIFY THAT NEITHER I NOR MY DEPENDENTS HAVE AN INJURY OR SICKNESS WHICH HAS A MATERIAL EFFECT ON LIFE EXPECTANCY. I UNDERSTAND UNUM IS RELYING ON THIS CERTIFICATION AS A MATERIAL CONDITION TO ITS AGREEMENT TO PROVIDE COVERAGE.

If Unum determines that an injury or sickness has a material effect on life expectancy, as of the date portable coverage was elected, benefits may be reduced to the amount of coverage available under the current policy's conversion privilege.

Insured Signature:	Today's Date (mm/dd/yyyy):	Insured's Email Address

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



PORTABILITY BENEFICIARY DESIGNATION FORM
 2211 Congress Street
 Portland Maine 04122
 Phone: 1-800-421-0344
 Fax: 207-575-2993

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). 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
		<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Policy Number	Division	BL Number
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		BL <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.



HOW TO CALCULATE YOUR PORTABILITY PREMIUM PAYMENT

<p>Calculate Your Premium Payment</p> <p>1. Find your rate on the rate table under appropriate tobacco use, if applicable. The rate is based on your age at the time your coverage terminates or is reduced.</p> <p>Note: You will qualify for non-tobacco premium rates if you have not used any tobacco products within the last 12 months.</p> <p>Your life insurance rates will continue to increase with age, every 5 years (for example, at age 50, 55, 60 etc.).</p>	<p>Base Rate Per \$1,000 of Coverage _____</p>															
<p>2. Determine the amount of insurance you want. You may have any amount up to and including the amount you had under the group plan.</p> <p>Note: You may be eligible to increase your coverage which would require Evidence of Insurability subject to maximums outlined in your former group insurance policy.</p>	<p>Amount of Coverage _____</p>															
<p>3. a. Base Rate Per thousand dollars of coverage:</p> <p>b. Number of thousand dollars you want:</p> <p>c. Multiply a. by b.:</p> <p>d. Mode you would like to pay quarterly = 3 Semi-annual = 6 Annual = 12</p> <p>e. TOTAL c. and d. This is your premium</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Base Rate</td> <td style="width: 10%;"></td> <td style="width: 40%;">_____</td> </tr> <tr> <td># of \$1,000 Units</td> <td style="text-align: center;">x</td> <td>_____</td> </tr> <tr> <td>Base Rate X # of Units</td> <td></td> <td>_____</td> </tr> <tr> <td>Mode Numeric</td> <td style="text-align: center;">x</td> <td>_____</td> </tr> <tr> <td colspan="2">*TOTAL</td> <td>_____</td> </tr> </table>	Base Rate		_____	# of \$1,000 Units	x	_____	Base Rate X # of Units		_____	Mode Numeric	x	_____	*TOTAL		_____
Base Rate		_____														
# of \$1,000 Units	x	_____														
Base Rate X # of Units		_____														
Mode Numeric	x	_____														
*TOTAL		_____														
<p>*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding</p>																
<p>Example:</p> <p>1. A 44 year old person decides to continue \$25,000 of coverage</p> <p>2. The person wishes to pay premiums annually</p> <p>3. The monthly rate for a 44 year old is \$.510 per \$1,000 of coverage</p> <p>4. Calculate premiums:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">a. Base rate per thousand dollars of coverage:</td> <td style="width: 20%; text-align: right;">\$.510</td> </tr> <tr> <td>b. Number of thousand dollar units you want:</td> <td style="text-align: right;"><u>x 25</u></td> </tr> <tr> <td>c. Multiply a. by b.:</td> <td style="text-align: right;">\$12.75 (Monthly)</td> </tr> <tr> <td>d. Multiply c. by 12 for annual</td> <td style="text-align: right;"><u>x 12</u></td> </tr> <tr> <td>e. TOTAL. This is your premium.</td> <td style="text-align: right;">\$153.00 (Annually)</td> </tr> </table>		a. Base rate per thousand dollars of coverage:	\$.510	b. Number of thousand dollar units you want:	<u>x 25</u>	c. Multiply a. by b.:	\$12.75 (Monthly)	d. Multiply c. by 12 for annual	<u>x 12</u>	e. TOTAL. This is your premium.	\$153.00 (Annually)					
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d. Multiply c. by 12 for annual	<u>x 12</u>															
e. TOTAL. This is your premium.	\$153.00 (Annually)															

Your actual coverage is subject to the terms, conditions, limitations and restrictions set forth in your certificate of coverage and the Summary of Benefits or Policy.

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