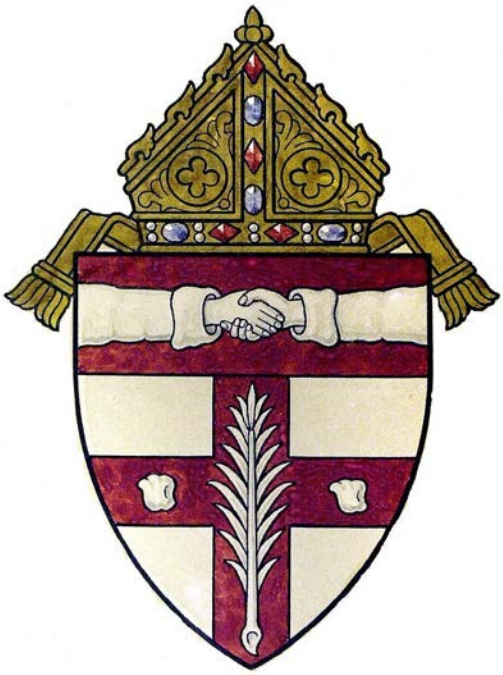
Diocese of Owensboro

Employee Exit Packet



2022/2023

Diocese of Owensboro

McRaith Catholic Center

TERMINATION DOCUMENTATION FORM

Employee Name:			
Location:			
Termination Date:		Last Day Worked (If Different):	
Forwarding Address:			

REASON FOR SEPARATION		
VOLUNTARY	☐ Without Notice or Reason	☐ Problem with Supervisor
	☐ Another Job	☐ Problem with Co-worker
	☐ Relocation	☐ Personal Problem
	☐ Illness	☐ Return to School
	☐ Pay	☐ Retirement
	☐ Working Conditions	☐ Refused Suitable Work
	☐ Work Schedule	☐ LOA - Did not return
	☐ Enlisted in Armed Forces	☐ Other
INVOLUNTARY	☐ Absenteeism	☐ Tardiness
	☐ Insubordination	☐ Unsatisfctory Performance
	☐ Violation of Rules	☐ Refusal to Follow Instruction
	☐ Lack of Work	☐ Job Eliminated or Changed
	☐ Other	☐ Involuntary Retirement

Explain the reason given above in detail:			
Employee's started reason for termintion:			
Is the employee eligible for rehire?	☐ YES	☐ NO	
If not elegible or only under certain conditions, explain:			

EXIT INTERVIEW			
☐ Interviewed by:		Date:	
☐ Exit questionnaire and sypnosis reviewed and filed.		Date:	
Follow-up required	☐ YES	☐ NO	

ITEMS RECEIVED FROM EMPLOYEE (ENTER N/A IF NOT APPLICABLE)		
	Received by	Date
Keys		
Keys fob		
Laptop /Computer		
Other		

PAYROLL		
	Date	
Final Paycheck		
Vacation (# of hours _____)		
Other		
BENEFITS		
☐ Insurance Terminated	☐ 403b Plan Terminated	☐ Retirement Terminated
☐ Self Pay ppw give to employee	☐ Self Insurance ppw give to employee	☐ Other
HR Signature:	Date:	
Printed Name:		

DIOCESE OF OWENSBORO
SELF PAY - EMPLOYEE BENEFIT PLAN PREMIUM RATES
RATES EFFECTIVE SEPTEMBER 1, 2022 to AUGUST 31, 2023

Medical/Dental/Prescription Coverage

	$700 Deductible	$2,500 Deductible
Single	**Monthly Rates**	**Monthly Rates**
Total Premium – Self Pay	**$984.00**	**$722.00**
Employee & Family		
Total Premium – Self Pay	**$1,907.00**	**$1,408.00**

Diocese of Owensboro
Health Benefit Plan

Self-Pay Privilege Notification Letter

Date: _____
Participant Name: _____
Address: _____
_____

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 Greg Pack at 800-446-8469.

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

Extended Continuation Election
Accident, Critical Illness, Hospital Indemnity

You can continue your Accident, Critical Illness, and/or Hospital Indemnity coverage when you leave your employer.

To keep your Accident, Critical Illness, and/or Hospital Indemnity coverage under extended continuation, fill out the attached application and return it to Anthem. We must receive your application within 31 days of your last day worked.

How much will it cost?

You'll pay the same rate for Accident and/or Hospital Indemnity that you paid through payroll deduction with your employer.

You'll pay the same rate for Critical Illness that you paid through payroll deduction with your employer but the Critical Illness rate is based on your age. When you move into a new rate bracket due to your age, your rate will change.

Call us at 1-844-639-0947 to find out how much your monthly premium will be to continue your coverage.

You'll get a bill each month for your continued coverage. You need to mail a check for your full premium amount shown on the bill and the payment coupon to Anthem every month, to the address shown on the payment coupon. If we do not receive premium within 31 days from the due date, your coverage will end and cannot be reinstated.

How long can I continue my coverage?

You can continue Critical Illness coverage and Accident coverage as long as your prior employer continues their Anthem plan, or until you reach age 85, whichever comes first. If your prior employer terminates their Anthem plan, your coverage ends when the Anthem plan ends.

You can continue your Hospital Indemnity coverage as long as your prior employer continues their Anthem plan, or until you reach age 85, or for three years, whichever comes first. If your prior employer terminates their Anthem plan, your coverage ends when the Anthem plan ends.

Can I continue coverage for my covered family members?

You can only continue coverage for your family members who you cover under your plan only if you elect to extend your own coverage. Family members' coverage can't be continued without also continuing your own coverage.

Your Certificate of Coverage

Keep the Certificate of Coverage your employer gave to you. The same Certificate of Coverage applies to your Extended Continuation coverage.

How can I get more information?

If you have questions about this information or need help filing out the Extended Continuation form, call us at 1-844-639-0947.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este document.

Extended Continuation Election

Use this form to continue your coverage after your employment ends

INSTRUCTIONS

Read and complete all of this form. Please use 4 digits for years.

Section 1: You can obtain this information from your former employer		
Former Employer/Association/Union Name	Group No.	Subsection

Section 2: Elect your extended coverage

I elect to continue my coverage for: ☐ Accident ☐ Critical Illness ☐ Hospital Indemnity

Extended coverage is at the same benefit level for you and your dependents as your active coverage.

Section 3: Your Information

Last Name	First Name	M.I.	Date of Birth (MM/DD/YYYY)

Social Security No.	Phone No.	Email Address

Street Address	City	State	Zip Code

Date Employment Terminated (MM/DD/YYYY)	Check here if address or email address updated ☐

Section 4: Premium Information and Payment

1. To get the premium amount for your extended continuation coverage, call 1-844-639-0947.
2. Fill in your premium amount here: $_____
3. Mail this Extended Continuation Election form to:

   Anthem
   Special Operations Unit
   8940 Lyra Drive
   Suite 300
   Columbus, OH 43240

Section 5: Authorization – read carefully before signing

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself. I certify the Social Security number listed on this application is correct.

I understand that no extended continuation coverage will be effective unless this Extended Continuation Election form and the full premium required have been submitted in accordance with the terms of the Group Policy. If not, any premium received will be refunded.

Extended continuation coverage will be effective on the first day following the termination of employment, provided that Anthem receives this completed Extended Continuation Election form within 31 calendar days after my coverage under the Group Policy would otherwise end.

For extended continuation coverage to remain in effect, I must continue to pay premiums by the first day of each month. Premiums are paid to the address shown on the payment coupon sent with the monthly bill. Extended continuation coverage will terminate if premium payments are not received within the 31 day grace period.

The terms of extended continuation coverage are set forth in the Certificate issued under the Group Policy. The amount of insurance in effect on the date my coverage would otherwise have ended will continue. No further increases to my benefit amount nor changes in amount of coverage will be allowed, nor will I be able to add any optional benefits.

The information on this form is true and complete to the best of my knowledge.

Employee Signature x	Date (MM/DD/YYYY)

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este document.

IMPORTANT ACCIDENT INSURANCE ELIGIBILITY INFORMATION:
The following notice applies to all Accident and Voluntary Accident coverage presented on this form:
ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

IMPORTANT CRITICAL ILLNESS INSURANCE ELIGIBILITY INFORMATION:
The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:
CRITICAL ILLNESS INSURANCE IS A SUPPLMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

IMPORTANT HOSPITAL INDEMNITY INSURANCE ELIGIBILITY INFORMATION:
The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:
HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

The laws of some states require us to provide you with the following information

California: For your protection California law requires the following statement 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.

Colorado: 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.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Virginia: 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.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.

New York: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

General Fraud Warning: Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal penalties.

Diocese of Owensboro

McRaith Catholic Center

To Employee of the Diocese of Owensboro

As you begin this transition in your life, you have options on continuing your life and accidental death and dismemberment (AD&D) insurance coverage that you have with Diocese of Owensboro. Outlined below are some details on the two continuation options you have:

- Portability
- Conversion

You may continue the amount of basic and supplemental life and AD&D insurance coverage that you have upon leaving employment from the Diocese of Owensboro. You may also choose to continue a lower amount of insurance.

Enclosed you will find a Portability application, a Portability Rate Sheet and a Conversion application including rates. If you decide to continue your life insurance coverage, you must choose either Portability or Conversion. You will find a brief description to aid you in making your selection.

Portability

Portability offers **group term life and AD&D coverage** in accordance with the plan you had under your employer, based on the portability rate sheet enclosed. The maximum amount of coverage you may continue under portability is the lesser of (a) 5 times your annual earnings, or (b) $750,000. Under the terms of the policy, you may be eligible to continue your life coverage upon termination of coverage or if you retire or you are working less than the minimum number of hours as described under the eligible groups in your plan. You are not eligible for portability if the reason for your loss of coverage is due to group policy termination or if you are on a leave of absence when you retire.

Conversion

Conversion offers **individual whole life coverage** with no supplementary benefits such as waiver of premium, accidental death and dismemberment or accelerated death benefit. However, there is a cash value build up, which begins after the whole life coverage has been in effect for two years (rate sheet enclosed). You will note that these rates are significantly higher than the Portability rates due to the cash value feature.

600 Locust Street, Owensboro, KY 42301-2130 • (270) 683-1545 • FAX (270) 683-6883 •www.owensborodiocese.org

You must apply for coverage by completing either the Portability form or the Conversion form. Application for either coverage must be made within **30 days** after your group insurance coverage ends, along with the required premiums made payable by check or money order to Unum Life Insurance Company of America. The completed form and premiums must be mailed to:

Unum Life Insurance Company of America
Portability/Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350

Failure to forward the applicable premiums with your application will result in a denial of your request to continue your coverage. Under the Portability coverage, you have the option to pay your premium annually, semi-annually or quarterly.

Applications received after the above noted deadlines or without required premiums will be denied.

To ensure you do not lose the opportunity to continue these valuable Employer sponsored benefits, if you intend to apply for continuation, please complete the forms contained in your exit packet. Please contact the Diocese of Owensboro HR department or the person responsible for benefits at you location if you have any questions.

If you have questions relevant to these options, your eligibility, or the status of your application, please call a Unum Life Insurance Company of America representative at 1-800-421-0344.

Sincerely,

The Diocese of Owensboro Human Resource Department

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.
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 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?** Individual Whole Life.
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: ☐ Terminated ☐ Reduced	Reason for Termination	Date of Termination or Reduction	Amount of Coverage Lost $
Was the employee disabled on date of termination or reduction? ☐ Yes ☐ No If yes, see (waiver of premium) Extension of Employee Life Insurance Provision of the group contract, if available under the group plan.		Date of Disability (Date last worked)	
Has Employee submitted a claim for extension of group benefit? ☐ Yes ☐ No		Was the group life coverage previously assigned? (collateral/absolute) ☐ Yes ☐ No	
Employer Signature		Date	

2. Employee Information

A. Print Insured's Name (Last, First, Mid. Int.)	Sex ☐ M ☐ F	Date of Birth
B. Applicant's/Dependent's Name (if other than insured)	Sex ☐ M ☐ F	Date of Birth

C. Insured's Address (No. & Street, City, State, Zip Code and Phone Number)

3. I elect the following life insurance:
☒ Individual 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
☐ Annually
☐ Semi-Annually
☐ Quarterly

6. Do you wish to elect automatic premium loan?
☐ Yes
☐ 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

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

AE-1066-KY (06/21)

How to Calculate Your Premium Payment

Calculate Your Premium Payment	**Check Your Elections Below**
1. Confirm your coverage election.	Whole Life ☐
2. If you have selected whole life, determine whether you want to pay your whole life premiums annually, semi-annually, or quarterly.	Annual ☐ Semi-Annual ☐ Quarterly ☐
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. **Calculate Your Premiums**

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. Add the policy fee:	Policy Fee	+ _____
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	_____

* This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding.

Example

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. Add the policy fee:	
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.	$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.

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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:

• 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	• 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 *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.* • Muscular dystrophy • Psychiatric hospitalization • Quadriplegia • Stroke • Systemic lupus erythematosus or any other rheumatologic disease

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, the lesser of 5x salary or $750,000 or the maximum allowed under your plan across all Unum Life and AD&D coverages combined.
- 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.
- Please remember to (1) include your ACH form; (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 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: Employee Name (Last, First, MI):	Policy Number Policy Number	Division Division	Class Class
Date Coverage Ends (mm/dd/yyyy): Current Annual Earnings:	Insured on disability or sick leave when terminated? ☐ Yes* ☐ No *If Yes, date premium paid to:	Reason for Loss of Coverage: ☐ Terminated Employment ☐ Retired ☐ Reduced Hours (must be working) ☐ Other, Explain	

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: ☐ Male ☐ Female
Spouse Name:	Spouse Date of Birth (mm/dd/yyyy):		Spouse Social Security Number:
Child Name:	Date of Birth: *	Child Name:	Date of Birth: *
Child Name:	Date of Birth: *	Child Name:	Date of Birth: *

* 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? ☐ Yes ☐ No

Has your spouse used tobacco products in the past twelve months? ☐ Yes ☐ 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				

ALL PREMIUMS TO BE PAID MONTHLY VIA AUTOMATIC PAYMENT. Please complete and send in the enclosed Authorization and Agreement for Automatic Payments form with your application.

☐ I am opting out of monthly payments and want to pay:
☐ Quarterly (Every three months) ☐ Semi-Annually (Every six months) ☐ Annually (One time per year)

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 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 ☐☐☐ - ☐☐ - ☐☐☐☐

Policy Number ☐☐☐☐☐☐ Division ☐

PART 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

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

PART 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

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

PART 4: Signature

X

Signature **Date**

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HOW TO CALCULATE YOUR PORTABILITY PREMIUM PAYMENT

Calculate Your Premium Payment	
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. **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.).	Base Rate Per $1,000 of Coverage _____
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. **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.	Amount of Coverage _____

3. a. Base Rate Per thousand dollars of coverage:	Base Rate	_____
b. Number of thousand dollars you want:	# of $1,000 Units	x_____
c. Multiply a. by b.:	Base Rate X # of Units	_____
d. Mode you would like to pay Monthly = 1 Quarterly = 3 Semi-annual = 6 Annual = 12	Mode	x_____
e. TOTAL c. and d. This is your premium	*TOTAL	_____

*This is the estimated amount due per payment, actual billed amount may vary slightly due to rounding

Sample Portability Premium Calculation:

1. A 44 year old person decides to continue $25,000 of coverage
2. The person wishes to pay premiums annually
3. The monthly rate for a 44 year old is $.510 per $1,000 of coverage
4. Calculate premiums:

a. Base rate per thousand dollars of coverage:	$.510 (sample rate)
b. Number of thousand dollar units you wanted:	x 25
c. Multiply a. by b.:	$12.75 (Monthly)
d. Multiply c. by 12 for annual	x 12
e. TOTAL. This is the sample premium amount.	$153.00 (Sample Annual Premium)

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 Life Insurance Company of America
Authorization and Agreement for Automatic Payments
Drawn By and Payable To:
Unum Life Insurance Company of America (hereinafter referred to as "the Company")
2211 Congress Street, Portland, Maine 04122
1-800-421-0344 Fax number: 207-575-2993
email to: PortabilityConversion@unum.com

PLEASE PRINT

BL#/POLICY NUMBER	INSURED NAME	SOCIAL SECURITY NUMBER

☐ Please apply this to all my policies

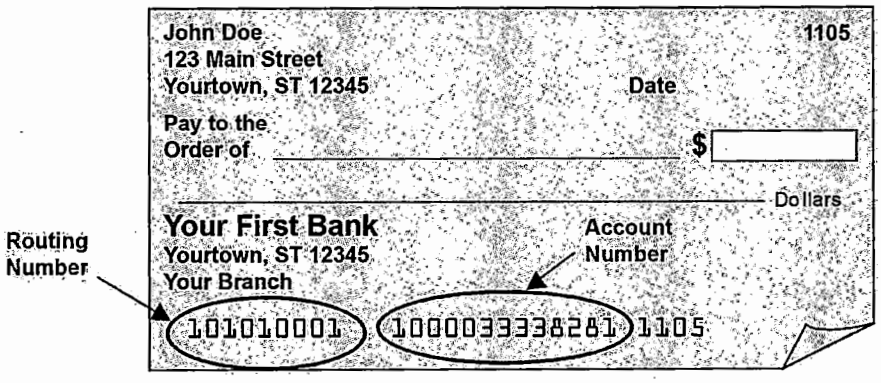
1. Purpose for submitting this authorization form:
   ☐ New Preauthorized payment plan ☐ Change in bank
   ☐ Addition of new policy to plan ☐ Change in account number

   Type of Account:
   ☐ Checking
   ☐ Savings

2. Current Address: _____
3. Name of Banking Institution: _____
4. Name on Bank Account: _____
5. Routing Number (9 digits): ___ ___ ___ ___ ___ ___ ___ ___ ___
6. Account Number: _____

Refer to the sample check for help locating the Routing Number and Account Number. Attach or scan a Voided Check (optional).

Sample Check



APPLICANT INFORMATION FOR BANK:

You are hereby authorized, as a convenience to me, to pay and charge to my account any check or electronic fund transfer drawn on this account on the first of the month by and payable to the order of the company(s) indicated above for itself (themselves), provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or transfer shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice and you have had a reasonable time to act on it. I agree that you shall be fully protected in honoring any such check or transfer.

I further agree that if any such check or transfer be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Signature of Depositor	Date
Please print name as signed above	

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

5. **Mail to:** Unum Life Insurance Company of America
2211 Congress Street
Portland Maine 04122
Mail or Fax to: 207-575-2993

I (each of the premium payors whose signature appears on the next page) have **carefully read** the terms of this authorization, and I **understand** and **agree** that:

1) This Authorization applies to coverage provided under the policy listed above and to any coverage subsequently added.
2) My signature on the next page reflects my intent that my account be debited by the Company in the amount necessary to pay premium.
3) No notice of premium due will be furnished while the Authorization is in effect, except, if any check or other debit entry made pursuant to this Authorization is not paid, the Company will send notice of premium past due.
4) It is my responsibility to fund my account in an amount sufficient to pay premium when due and failure to do so may result in lapse of coverage.
5) This Authorization does not waive, alter or amend any provision of coverage under the above policy.
6) No premium shall be deemed paid until the Company receives payment at its Home Office.
7) The Company shall incur no liability as a result of the dishonor of any debit entry or any check, draft or other instrument drawn pursuant to this Authorization Agreement.
8) This Authorization shall remain in effect unless and until the bank, the insured person or premium payor presents written notice of termination to Unum.
Exception: The Company may terminate this Agreement, by providing written notice thereof, in the event that, within any period of twelve consecutive months, two or more premium debits are not paid upon presentation, or if any time the Company is required to refund to the bank any amount paid pursuant to this Authorization.
9) Upon termination of this Agreement, premiums will be payable at the rate (amount) and mode (frequency) required under the Company's usual rate and mode for coverages not enrolled in the Automatic Payment Plan.
10) Funds must be paid in U.S. dollars and withdrawn from a U.S. bank.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL
Please retain a copy of this form for your records

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, First Unum Life Insurance Company and Provident Life and Accident Insurance Company.

THIRD PARTY AUTHORIZATION
PORTABILITY PROTECTION PLAN
Unum Life Insurance Company of America
Unum Insurance Company
2211 Congress Street
Portland, ME 04122
Attention: Portability/Conversion Unit
Fax: 207-575-2993

For toll-free assistance call: 1-800-421-0344

POLICY OWNER NAME	BL#							
	BL#							

AUTHORIZED INDIVIDUAL(S) NAME	Relationship to the Policy Owner	PHONE NUMBER

I authorize Unum Group, its subsidiaries and affiliates* and duly authorized representatives ("Unum") to disclose the following insurance plan, policy billing and beneficiary information to the person(s) or organization(s) listed above, for the purpose of assisting me with my insurance coverage:

- Information regarding my coverage, including policy provisions and riders;
- Information regarding premium calculation, invoicing and payments; and
- Name(s) of designated beneficiaries (if applicable).

This authorization does not alter any prior designation made under any law protecting against unintentional lapse of coverage.

This authorization does not allow the authorized individual(s) or organization(s) to make any changes to my coverage, policy, riders, beneficiary designations, or assignments under my policy.

This Authorization does not allow Unum to share claim or health information including, but not limited to, my medical condition, diagnosis, treatment, or pre-existing condition information; the names of my physicians and other medical providers; or benefit amounts paid to me or on my behalf.

Unum will rely on this authorization until I revoke it in writing.

Unum may provide information in writing, electronically, or by telephone (including voice mail messages).

CERTIFICATION

- **I understand that once information is disclosed to the named authorized Individuals or Organizations, it may no longer be protected by federal privacy regulations.**
- I am not required to sign this authorization and Unum may not condition payment of claims on whether I sign this authorization.
- I am entitled to receive a copy of this authorization.
- I may revoke this authorization in writing at any time, except to the extent that Unum has relied on the authorization prior to notice of revocation.

_____ _____

Policy Owner Signature Date Signed

_____

Print Name

*This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life Accident Insurance Company and Provident Life and Casualty Insurance Company.

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LIFESTYLE PROTECTION℠ LIFE INSURANCE
ELECTION OF PORTABILITY COVERAGE
Unum Life Insurance Company of America (Unum)
2211 Congress Street, Portland, Maine 04122

Send To: Unum, Portability Unit, 2211 Congress Street, Portland, Maine 04122-1760, 1-800-421-0344

Initial Enrollment

You may be eligible to continue your Lifestyle Life/AD&D coverage. You must complete this form and send it to Unum within 31 days after your group insurance coverage ends.

The portability privilege is not available if you:
- Left employment because of injury or sickness.
- Your coverage terminated because of a reduction of hours.

You must include your first premium payment, which is based on the premium option you select. **Send the completed form and premium payment to the address shown above.**

Premium payment options:

Check your preferred frequency of premium payment. Once coverage is continued, bills will automatically be sent to your home address as given below.

☐ Quarterly (monthly premium x 3)
☐ Semi-Annually (monthly premium x 6)
☐ Annually (monthly premium x 12)

Company Name:	Plan Number/Division Number:
Insured Name (last, first, initial):	Home Telephone #: Work Telephone #:
Insured Mailing Address (Street, P.O. Box, City, State, Zip):	Current Annual Salary

Social Security Number	Date of Birth:	Date coverage ended: Reason:	Sex: ☐ Male ☐ Female

Insured Coverage

Maximum Life coverage amount is 5 times your salary up to a maximum of $500,000, subject to medical underwriting.
For AD&D coverage the maximum amount is 10 times your salary to a maximum of $500,000.

Life Coverage In Force: _____
I request a change to: _____
Accidental Death & Dismemberment Coverage Elected: _____
I request a change to: _____
☐ Smoker ☐ Non Smoker

Spouse Coverage

To have Life coverage for your spouse, you must have Life coverage for yourself.

Maximum coverage for your spouse is 100% of your coverage. If your former employer is located in one of the following states, the maximum is 50% of your coverage: AZ, AR, CA, D.C., FL, IN KS, LA, NJ, OK, WA, WY.

Life Coverage In Force: _____
I request a change to: _____
Accidental Death & Dismemberment Coverage Elected: _____
I request a change to: _____
Date of Birth: _____

Child Coverage (Dependent children can be covered to age 19 or if a student in an accredited school to age 25.)

To have Life coverage for your child, you must have Life coverage for yourself.

Maximum coverage is 50% of your coverage.

Life Coverage In Force: _____
I request a change to: _____
Accidental Death & Dismemberment Coverage Elected: _____
I request a change to: _____

Beneficiary

Name of Beneficiary _____ Relation to you _____

Insured Signature _____ Date _____

Please Retain a Copy for Your Records

Frequently Asked Questions

This FAQ is to assist you in answering questions you may have or receive about the communication received from Unum regarding portability premium rate changes.

If you have additional questions after reviewing the FAQ, please contact your Unum representative, or contact us at AskUnum@unum.com.

Please note that existing group employer rates are NOT changing. The change applies to portability rates.

Q What is portability?

A Portability is a continuation of coverage option under Unum's group term life and AD&D insurance policies. When an employee's relationship with their employer changes — either because they're leaving the company, or they're no longer eligible for coverage — portability provides an option for employees to keep their term life and AD&D coverage at group rates. This is also called "porting" coverage.

Q Why am I receiving this communication?

A After careful consideration, Unum has determined it is necessary to adjust group life portability rates. This communication is to inform you that your group life portability rates are changing effective May 1, 2022.

Q What coverages may be impacted?

A Your life insurance portability rates are impacted.

Q I thought the portability premium rates would never change.

A Unum periodically reviews experience and reserves the right to adjust premium rates for portable coverage based on financial experience and demographic trends. These changes are separate from the regular rate adjustments that occur when the insured reaches a new age bracket.

Q How were the new portability premium rates determined?

A The portability rates were updated based on Unum's review of the claim experience and demographic trends and encompassed the analysis of both past and expected future experience of the block.

Q What is the effective date of my client's portability rate change?

A The new portability rates become effective May 1, 2022. Employers should update the portability rates offered to employees who qualify for the portability provision coverage after April 1, 2022 for an effective date of May 1, 2022. It is important that you update the group life portability rates anywhere they may have been posted for you and your employees' reference. Please also communicate this information to your Benefit Administration partners as needed.

Q Will employer portability rates be adjusted in the future?

A Unum tries to minimize changes to the premium rates but reserves the right to make adjustments in order to meet future claims obligations.

Q What are the new portability rates?

A Please refer to the attached rate sheet for the new life insurance portability rates.

Q Will those who have already ported their coverage be impacted?

A Employees who have ported their coverage may be impacted. Unum is communicating directly with individuals who are impacted.

Q I have Unum's AMS Portability & Conversion Services, what do I need to do?

A Please update the group life portability rates anywhere they may have been posted for you and your employees' reference. If Unum provides Portability and Conversion Services to your company, the portability application package provided to insureds from Unum will be updated by Unum to reflect the new portability rates

Group Life and AD&D Portability Rates

Employee/Insured Life Rates:

Age	Non-Tobacco Monthly Rate Per $1,000	Tobacco Monthly Rate Per $1,000
0-24	$0.09	$0.13
25-29	$0.09	$0.13
30-34	$0.09	$0.14
35-39	$0.12	$0.20
40-44	$0.17	$0.30
45-49	$0.27	$0.48
50-54	$0.42	$0.80
55-59	$0.68	$1.12
60-64	$1.01	$1.57
65-69	$1.76	$2.61
70-74	$3.17	$4.58
75-79	$5.35	$6.91
80-84	$8.50	$9.56
85-89	$12.26	$12.63
90+	$24.58	$24.58

Spouse Life Rates:

Age	Monthly Rate Per $1,000
0-24	$0.13
25-29	$0.13
30-34	$0.14
35-39	$0.19
40-44	$0.27
45-49	$0.42
50-54	$0.66
55-59	$1.00
60-64	$1.74
65-69	$2.99
70-74	$5.32
75-79	$8.72
80-84	$13.40
85-89	$19.05
90+	$37.83

Child Life Rates: $0.28 per $1,000 of coverage monthly

Accidental Death & Dismemberment Rates: No change in current AD&D port rates.

Diocese of OWENSBORO

Confidential

Employee Exit Interview Form

Date: _____

Name: _____

Location/Department: _____ Supervisor: _____

Hire Date: _____Termination Date: _____

Starting Position: _____Ending Position: _____

Starting Salary: _____Ending Salary: _____

Part 1: Reason for Leaving

(More than one reason may be given if appropriate; if so, circle the primary reason.)

Reason for Resignation:

___Took another positon

___Pregnancy/home/family needs

___Poor health/physical disability

___Relocation to another city

___Travel difficulties

___To attend school

___ Other: _____

Dissatisfaction with:

___ Salary

___ Type of work

___ Supervisor

___ Co-workers

___ Working conditions

___Benefits

___ Other: _____

Laid off due to:

___ Lack of work

___ Abolition of position

___ Lack of funds

___ Other: _____

Type of Retirement:

___ Voluntary retirement

___ Disability retirement

___ Regular retirement

Plans after leaving:

_____

_____

_____

Part II: Comments/Suggestions for Improvement

We are interested in what our employees have to say about their work experience with the Diocese of Owensboro. Please complete this form.

1. What did you like most about your job?

_____

_____

2. What did you like least about your job?

_____

_____

3. How did you feel about the pay and benefits?

	Excellent	Good	Fair	Poor
Rate of pay for your job	☐	☐	☐	☐
Paid holidays	☐	☐	☐	☐
Paid vacations	☐	☐	☐	☐
Retirement plan	☐	☐	☐	☐
Medical coverage for self	☐	☐	☐	☐
Medical coverage for dependents	☐	☐	☐	☐
Life Insurance	☐	☐	☐	☐
Sick leave	☐	☐	☐	☐

4. How did you feel about the following:

	Very Satisfied	Slightly Satisfied	Neutral	Slightly Dissatisfied	Very Dissatisfied
Opportunity to use your abilities	☐	☐	☐	☐	☐
Recognition for the work you did	☐	☐	☐	☐	☐
Training you received	☐	☐	☐	☐	☐
Your supervisor's management methods	☐	☐	☐	☐	☐
The opportunity to talk with your supervisor	☐	☐	☐	☐	☐
The information you received on policies, programs, projects, and problems.	☐	☐	☐	☐	☐
Promotion Policies and practices	☐	☐	☐	☐	☐
Discipline policies and practices	☐	☐	☐	☐	☐
Overtime policies and practices	☐	☐	☐	☐	☐
Performance review	☐	☐	☐	☐	☐
Physical working condition	☐	☐	☐	☐	☐

Comments:

_____

_____

_____

_____

5. If you are taking a new job…
    a. What kind of work will you be doing?

_____

_____

b. What has your new place of employment offered you that is more attractive than your present job?

_____

_____

6. Could your employer have made any improvements that might have influenced you to stay on the job?

_____

_____

Other remarks (optional):

_____

_____

_____ _____

Employees Signature Date

DO NOT WRITE BELOW THIS LINE. OFFICE USE ONLY. PLEASE RETURN TO YOUR EMPLOYER.

( ) *Discussed with employee*

☐ *Benefits*

☐ *Payment of unused time and last paycheck*

_____

_____ _____

Interviewer's Signature Date