LIFESTYLE PROTECTION℠ VOLUNTARY LTD PORTABILITY APPLICATION
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Mail to: Unum, Portability/Conversion Unit, 2211 Congress Street, Portland, Maine 04122-1760, 1-800-421-0344

SECTION 1: To be completed by the Employee

You may be eligible for continuation of your Lifestyle Group Long Term Disability Insurance. If you wish to exercise your Portability Privilege, please provide Unum with the following information.

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #

Are you enrolled or eligible to enroll for any other Group Long Term Disability coverage?
☐ Yes ☐ No

If you are approved for Portability, the Lifestyle Protection Plan Coverage will cease when the first of the following occurs:
a. the date you fail to pay the required premium;
b. the date you retire;
c. the date the policy terminates;
d. the date you become insured for Long Term Disability insurance under any other group long term disability income plan.

If you wish to apply for this coverage you must submit this completed application to Unum's Home Office. If the application is not received by Unum within 31 days after termination of employment you will be ineligible to apply. Upon approval of this application a letter confirming coverage and a quarterly billing statement will be sent directly to you at the address provided.

Employee Signature	Date (mm/dd/yyyy)

SECTION 2: To be completed by the Employer

Employer Name	Portability Number **294999-0001**	Current Premium Payment
St/PO Box		Date (mm/dd/yyyy)

City		Date of Termination of Employment (mm/dd/yyyy)
State	Zip Code	Employee's basic monthly earnings at time of termination $
Employee's Occupation at time of termination		Reason for Employee termination

Is employee terminating employment as a result of retirement, leave of absence, injury or sickness?
☐ Yes ☐ No If yes, the employee is not eligible for coverage under the terms of the contract.

Employer Representative Signature	Plan Number

Please retain a copy of this form for your records.

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