

- 1. Conversion rights** – When your group life insurance terminates or the amount of coverage you have is reduced, you can convert your coverage to any available Policy offered by the Company at that time. You may elect any Policy without having to provide evidence of insurability.
- 2. Application process** – You have 31 days from the date of loss of coverage to apply if notice is given 15 days before or after the termination of coverage. You have 45 days from the date of notice to apply for conversion only if notice is given more than 15 days after the loss of coverage. You have 90 days from the date of the loss of coverage to apply if no notice is given. Coverage under the group policy will continue under these periods if applicable unless a successful application for the individual policy has been made.

Submitting your Conversion application

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?** 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.
 - Owner 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.**

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 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? <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:
 Individual Whole Life Policy - Form # FUL-21848
 Individual Whole Life Policy - Form # FWL 1.0
 Single Premium Convertible One-Year Term Life - Form # FOT 1.0

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
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7. Whom do you wish as beneficiary(ies) of proceeds under the individual policy?
 Primary Beneficiary:
 Name (First, Middle, Last) _____ Relationship to You _____
 Address _____ SS# _____ Telephone _____ DOB _____
 If beneficiary(ies) named above not living, then pay:
 Contingent Beneficiary:
 Name (First, Middle, Last) _____ Relationship to You _____
 Address _____ SS# _____ Telephone _____ DOB _____

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 after coverage under the Group Policy is reduced or terminated. (4) The beneficiary designation above has no effect on the beneficiary designation for any death benefits payable under the Group Policy. (5) If you die during the Conversion application period without having made successful application for conversion any death benefit (equal to the full amount of death benefit payable under the Group Policy) will be paid under the Group Policy. In this case, we, First Unum Life Insurance Company, will refund to the beneficiary any premium paid for the Individual Policy. If successful application for conversion has been made, any death benefit will be paid under the Individual Policy. (6) The application is attached to and made part of the policy.

8. Insured's Signature	Date	Applicant's/Dependent's Signature	Date	Owner Signature (if other than insured)	Date
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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 for Individual Whole Life or Convertable One year Term life

NOTE: You will need to call 1-800-421-0344 for premium rates on the Scheduled Premium Whole Life or the Flexible Premium Universal Life. These rates are not available on this application.

<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.	<table style="width: 100%;"> <tr> <td style="width: 50%;">Whole Life</td> <td style="width: 50%;">1-Year Term</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Whole Life	1-Year Term	<input type="checkbox"/>	<input type="checkbox"/>		
Whole Life	1-Year Term						
<input type="checkbox"/>	<input type="checkbox"/>						
2. If you have selected whole life, determine whether you want to pay your whole life premiums annually, semi-annually, or quarterly.	<table style="width: 100%;"> <tr> <td style="width: 33%;">Annual</td> <td style="width: 33%;">Semi-Annual</td> <td style="width: 33%;">Quarterly</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Annual	Semi-Annual	Quarterly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Annual	Semi-Annual	Quarterly					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
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>						
	* 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 <u> 25</u>						
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	<u> -</u>						
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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AE-1066-NY (06/21)



First Unum Life Insurance Company
 Provident Life and Casualty Insurance Company
 The Paul Revere Life Insurance Company

As part of your enrollment for insurance with Unum, please complete this form and submit it with your application. Also, in order to effectively identify and locate beneficiaries and help ensure that benefits are distributed appropriately upon the death of an insured or additional named insured, we request information in writing from time-to-time, including when we become aware of a change regarding you, your beneficiary(ies), additional named insured or the owner of your life insurance coverage. Please fill in the requested information below.

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)		Social Security Number
Mailing Address	Telephone Number	Date of Birth

SECTION 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
Total Must Equal 100%					

SECTION 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
Total Must Equal 100%					

SECTION 4: Additional Named Insured/Spouse

Name (Last Name, Suffix, First Name, MI)		Social Security Number
Mailing Address	Telephone Number	Date of Birth

SECTION 5: Additional Named Insured/Spouse 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
Total Must Equal 100%					

SECTION 6: Additional Named Insured/Spouse 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 & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
Total Must Equal 100%					

SECTION 7: Owner

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

Name & Mailing Address (Last Name, Suffix, First Name, MI)	Telephone Number	Relationship to You	Social Security Number	Date of Birth	Percentage
Total Must Equal 100%					

SECTION 8: Signature

X _____ **Date** _____
Employee Signature

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AE-1173-NY (02/13)