



What is Portability of Accident Insurance?

As part of the Accident coverage provided by your Employer, a feature was included in the policy to allow you and your spouse and children to continue this coverage when you terminate employment with the employer or are no longer in an eligible group. Portability of Accident Insurance provides the same coverage at the same group rates.

Important facts to remember (See Portability of Accident Insurance in your certificate)

- Portability is not available if the policy is cancelled by Unum.
- You may continue coverage for yourself, your spouse and/or children at the current benefit plan option. You may also choose to remove coverage for your spouse and/or children. If your employer's plan includes a lower option, coverage may also be lowered, but not increased.
- If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.
 - Otherwise, your ported coverage will end on the earliest of:
 - the date you fail to pay the required premium within 31 days of a premium due date;
 - the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
 - the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice
 - the date you die; or
 - for coverage situated (state that governs the contract) in Kentucky, Ohio and Tennessee, the date the Employer's policy terminates.
 - Your Spouse's ported coverage will end on the earliest of:
 - the date your ported coverage ends;
 - the date your Spouse is no longer eligible for coverage;
 - the date your Spouse no longer meets the definition of a Spouse;
 - the date of your Spouse's death; or
 - the date of divorce or annulment.
 - If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage.
 - Your Children's ported coverage will end on the earliest of:
 - the date your ported coverage ends;
 - the date your Children are no longer eligible for coverage; or
 - the date your Children no longer meet the definition of Children.

What are the Employer's responsibilities?

- Fully complete Section 1 of the election form and provide to the participant. Incomplete election forms may result in a denial of the applications.
- Determine if terminating employee is eligible to apply for Portability of Accident Insurance (see certificate for detailed requirements).
- Provide separate election forms when portability is offered under more than one insurance policy.
- Provide premium rates and portability election forms to eligible termination employees eligible to port coverage.

What are the Employee's responsibilities?

- Fully complete Section 2. Sign and date the election form. Incomplete election forms may result in a denial of the application.
- Select if you want to keep existing or reduce (if available) coverage for you, your Spouse and your Children. Any changes to Children coverage applies to all eligible children.
- Designate a beneficiary using the form provided.
- Send the election form to 2211 Congress Street, Attn: Portability Unit, Portland, ME 04122 or fax to 207-575-2993.
- Please remember to:
 - include your ACH form;
 - sign and date the election form with today's date;
 - designate a beneficiary;
 - contact us when your last child reaches age 26 to cancel child coverage.

Retain a copy of this for your records.

Section 1: Employer Completes			
Company Name:	Policy Number	Division	Class
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>
Employee Name (Last, First, MI):	Date Coverage Ends (mm/dd/yyyy):		

Fill in Current Elected Coverage Amounts for Each Insured

Insured Type	Accident
Employee	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 (if applicable)
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> Yes <input type="checkbox"/> No

Plan Administrator Name: _____ Plan Administrator Signature: _____

Plan Administrator Telephone Number: _____ Plan Administrator Email: _____

Section 2: Insured Completes		
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: <input type="checkbox"/> continue coverage <input type="checkbox"/> drop coverage	Spouse Date of Birth (mm/dd/yyyy):	Spouse Social Security Number:
Child Coverage: <input type="checkbox"/> continue coverage <input type="checkbox"/> drop coverage		

Check the policy or your certificate. Child eligibility is subject to age limits.

Fill in Requested Coverage.

Insured Type	Accident
Employee	<input type="checkbox"/> Continue Coverage <input type="checkbox"/> Reduce Coverage (subject to availability)

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 accident insurance coverage under which this coverage is being offered and is subject to satisfaction of the conditions provided therein.

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: 800-635-5597
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										
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PART 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Accident 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 _____ **Date** _____
Signature Date

**Provident Life and Casualty
Insurance Company**



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

PLEASE PRINT

BL#/POLICY NUMBER	INSURED NAME	SOCIAL SECURITY NUMBER

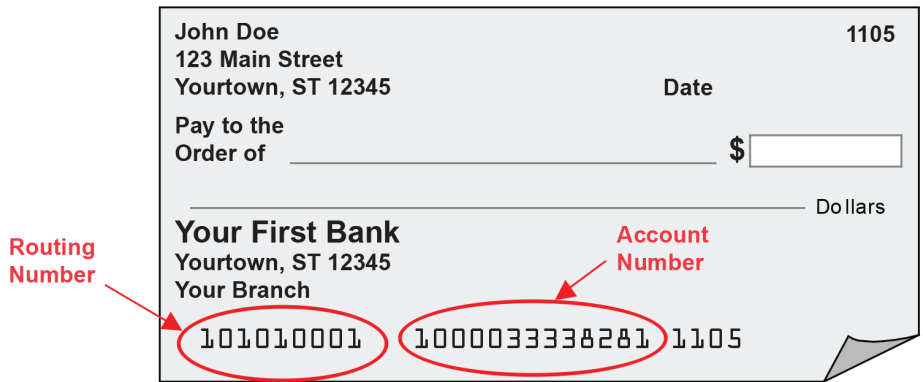
You can set up recurring payments or make a single payment online <https://pay.unum.com>.

Please apply this to all my policies

1. Purpose for submitting this authorization form: _____ Type of Account: _____
- New Preauthorized payment plan Change in bank Checking
 Addition of new policy to plan Change in account number 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