ELECTION OF PORTABILITY COVERAGE – GROUP TERM LIFE INSURANCE AND AD&D COVERAGE
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
PO BOX 1365 COLUMBIA, SOUTH CAROLINA 29202

If your group coverage ends due to employment termination, retirement or reduction in hours, you may be eligible for portable coverage. To apply you must complete this form and send it to us within 31 days after your group life insurance coverage ends. If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage. Ask the policyholder for a conversion application form (which includes cost information).

Please obtain your portability premium rates from your plan administrator and mail your initial premium payment, along with this election form, to the address shown above. **Make your check or money order payable to Colonial Life & Accident Insurance Company.**

SECTION 1: EMPLOYER INFORMATION (to be completed by the employer)		
Policyholder Name Scotland County Schools	Group Policy Number	Billing Control Number E4332912 - Basic GTL
Policyholder Home Office Address - Street City State Zip Code 322 South Main Street, Laurinburg, NC 28352		Business Phone No.
Reason for Termination / Reduction	Date of Termination: mm/dd/yyyy	Is portability guaranteed? ☑ Yes ☐ No
Policyholder Signature (x)Date:_____ Administrator		----____ Employer / Plan mm/dd/yyyy

SECTION 2: APPLICANT INFORMATION (to be completed by the applicant)			
Insured Name (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street City State Zip Code			Home Phone No.
Email Address			Business Phone No.
Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?			Yes ☐ No ☐
Within the past 12 months have you submitted evidence of insurability to Colonial Life for group coverage?			Yes ☐ No ☐

You may keep the same level of coverage or decrease coverage. You may also increase coverage (for you) or add dependent(s) (if your policyholder's plan has spouse or dependent children coverage) subject to medical evidence of insurability. **If you increase coverage or add dependent(s) a separate evidence of insurability form must be completed.**

NOTE: For specific plan maximums/minimums, rounding rules and reduction formulas refer to your plan administrator. If you have any questions concerning your or your dependent's eligibility for portability coverage, please contact us at 1-800-845-7330. If no dependent or AD&D coverage is available under your group plan, then any reference to "dependent" or "AD&D" is not applicable.

SECTION 3: COVERAGE ELECTIONS – The employee must port coverage, if applicable, in order for any eligible spouse or dependent children to be eligible to port.		Face Amount	Monthly Premium
☑ **Employee**	**No change** ☑ **Decrease** ☐	$ 10,000	$ 0.90
☐ **Spouse**	**No change** ☐ **Decrease** ☐	$	$
☐ **Dependent Children**	**No change** ☐ **Decrease** ☐	$	$
Is AD&D coverage being ported? ☐ Yes ☐ No		**Total Monthly Premium**	$ 0.90
Select a premium payment option:	☐ Bank Draft (monthly premium) ☐ Semi-Annually (monthly premium x6)	☐ Quarterly (monthly x3) ☐ Annually (monthly premium x12)	

SECTION 4: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if porting spouse and/or dependent children coverage

Name (First, MI, Last)	Gender	Birthdate(mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			

SECTION 5: EMPLOYEE BENEFICIARY INFORMATION – if completed this beneficiary designation will replace any current beneficiary designation on file with us.

Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 6: EVIDENCE OF INSURABILITY (required if Portability is not guaranteed and you are not increasing coverage or adding a spouse / dependent)		
If you answer yes to any question please provide details on the following page.	**Proposed Insured**	**Spouse**
1. (Employee only) Indicate Your Current: Height_____Weight_____		
2. Does any proposed insured have a medical condition which has a material effect on life expectancy, including, but not limited to, heart or cardiovascular disease or impairment, cancer or tumor, lung or respiratory disorder, kidney or genitourinary disorder, digestive disorder, diabetes, mental, nervous or nervous system disorder?	Yes ☐ No ☐	Yes ☐ No ☐
3. Within the past 5 years, has any proposed insured been confined to a hospital or medical facility, seen a member of the medical profession for any reason other than stated on this application, or are currently taking medication or receiving medical advice by a member of the medical profession?	Yes ☐ No ☐	Yes ☐ No ☐
4. Within the past 3 years, has any proposed insured used illegal or illicit drugs, received 3 or more speeding tickets or moving violations, been charged with driving while intoxicated, or pled guilty to, pled no contest to, have a charge pending or been convicted of a felony or misdemeanor?	Yes ☐ No ☐	Yes ☐ No ☐

SECTION 7: DETAILS FOR ANY "YES" ANSWERS IN SECTION 6					
Name	**Detailed Description**	**Date**	**Duration**	**Treatment Received**	**Name & Address of Physician / Hospital**

I understand and agree to the following:

1. Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's Colonial Life group term life insurance coverage under which this coverage is offered and is subject to satisfaction of the conditions provided therein.

2. Portability coverage will become effective the day after the group coverage terminates subject to Colonial Life receiving a completed election form and the first premium within 31 days from the date group coverage terminates.

_____ _____

Applicant/Employee Signature Date (mm/dd/yyyy)