



## APPLICATION TO PORT GROUP TERM LIFE INSURANCE COVERAGE

—Please Type Or Print Clearly In Dark Ink—

Employees and their insured dependents may be eligible to continue Group Term Life Insurance coverage if their coverage under the Employer Group Term Life Insurance Policy terminates. Employees should see the Certificate of Coverage for details regarding the right to port coverage.

In order to port your coverage you must complete this Application and submit it to Renaissance within the time-frame outlined in your Certificate of Coverage. Note that the first section of this Application must be completed by your Employer.

### SECTION I | EMPLOYER INFORMATION (Policyholder Use Only)

Name of Employer:		Group ID Number:	Billing Class:
Unit Name and Number:		Policy Number(s):	
Date Group Life Benefits Terminated:		Reason Group Life Benefits Terminated:	
Was The Employee Receiving A Waiver Of Premium Benefit On The Date Of Termination? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", the Employee is not eligible to apply for Portable Group Term Life Insurance</i>			
Signed By Policyholder:	Job Title/Occupation:	Date:	Telephone (include area code):

Attach Current Proof Of Coverage (Benefits Statement, Enrollment Form.)

### SECTION II | EMPLOYEE INFORMATION (Completed By Applicant)

Full Name (Last, First, MI):	<input type="checkbox"/> Male	Email:	
	<input type="checkbox"/> Female	Phone:	
Street Address (Include Apt#/Suite):	City:	State:	ZIP Code:
Social Security Number:	Date of Birth (mm/dd/yyyy):	Job Title/Occupation:	

Individuals Applying To Port Coverage:  Employee  Employee's Insured Spouse  Employee's Insured Child

Employee must port coverage in order for any Dependents to port.

### SECTION III | COVERAGE ELECTIONS

Amount(a) Of Life Insurance In Force Prior To Termination:

Basic Life: \$ \_\_\_\_\_

Supplemental Life: \$ \_\_\_\_\_

Amount(s) Of Life Insurance To Be Ported *(May Not Be More Than You Had In Force)*: Basic Life: \$ \_\_\_\_\_

Supplemental Life: \$ \_\_\_\_\_

### SECTION IV | BENEFICIARY (Will Revoke Any Existing Beneficiary Designations)

Full Name (First, Last, MI)	Relationship To You	Social Security Number	Percentage

If you need more room, please request our Beneficiary form

*[Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.]*

### SECTION V | EFFECTIVE DATES

The effective date of the coverage applied for will be the date of termination of your insurance under the Policy Number designated in the Employer Section on page one, but it is agreed that coverage shall not become effective until: (a) this Application has been approved by Renaissance at its Home Office; and (b) a check equal to the first premium payment has been received by Renaissance at its Home Office.

If your Application is approved, you will be billed for your first premium payment. *(Subsequent premium payments will be billed to you in accordance with the premium mode selected by you.)*

### SECTION V | PREMIUM MODE

Premium Modes Available *(Check one)*:  Monthly  Quarterly  Semi-Annual  Annual

### SECTION VI | APPLICANT CERTIFICATION

My deposit premium check for \$20.00 is enclosed for the coverages selected. This check will be applied to my initial premium if my application is approved and will be returned to me if my Application is not approved. I understand that I must pay the balance of the annual premium within 31 days after the date this application has been approved by Renaissance.

I understand that I am applying for group life insurance coverage under a policy issued to the Renaissance Family Group Insurance Portability Trust, and that such coverage can be terminated by Renaissance on any January 1 upon 60 days prior written notice. I certify that to the best of my knowledge and belief all foregoing statements and answers are true.

**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.**

Applicant Signature

Date of Birth *(Month/Year)*

Date

**FOR RENAISSANCE USE ONLY:**

Application Approved on: \_\_\_\_\_ to be Effective: \_\_\_\_\_ By: \_\_\_\_\_

