CHUBB®

EDUCATOR INCOME REPLACEMENT PLAN
REQUEST FOR PORTABILITY OF COVERAGE

Submit to: Chubb, P.O. Box 6703, Scranton, PA 18505-0703
Email: CWBPortabilityConversion@Chubb.com; Toll Free Number: 888-499-0425

EMPLOYER COMPLETES SECTION 1

Company Name:	Policy Number	Division	Class
Employee Name (Last, First, MI):	Policy Number	Division	Class

Date Coverage Ends (mm/dd/yyyy):	Reason for Loss of Coverage:	Has insured been covered for 12 months under this policy?
Current Annual Earnings: $_____	☐ Terminated Employment ☐ Other - Explain	☐ Yes ☐ No

Fill in Current Coverage Amounts for Employee's and Each Insurance Type

Insured Type	Current Disability %	Current Flat Dollar Benefit
Employee		

Plan Administrator Name

Plan Administrator Signature

Plan Administrator Telephone Number

Plan Administrator Email

EMPLOYEE COMPLETES SECTION 2

Mailing Address (Street, PO Box, City, State, Zip):		Home Telephone: Alternate Telephone:
Social Security Number:	Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Female

Fill in Requested Coverage Amounts for Insured's and Each Insurance Type - coverages left blank will result in a coverage amount of $0.

Insured Type	Requested Disability %	Disability Requested Flat Dollar Benefit
Employee		

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 understand and agree to the following:

Any coverage chosen on this request form will only be issued in accordance with the portability provision contained in the Employer's Group Disability Income policy under which this coverage is being offered, and is subject to satisfaction of the conditions provided therein.

Once an application for portability has been received and approved, portable coverage will be effective the day after coverage would have otherwise ended under the Employer's policy, so long as your initial premium payment is received.

I CERTIFY THAT I AM NOT DISABLED OR RETIRING. COVERAGE MAY BE CANCELLED IF I REMAIN UNEMPLOYED FOR TWELVE (12) CONSECUTIVE MONTHS.

Signature:	Today's Date (mm/dd/yyyy):	Email Address:

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Important Information When Considering Portability Coverage

When your Educator Income Replacement insurance coverage ends, either because your employment has terminated or you are no longer eligible to participate in your employer's income replacement policy, you may be eligible to port your policy. Portability allows you to continue (or 'port') your coverage at group rates. The ported coverage will be subject to the same provisions contained in your employer's income replacement policy. Some key considerations are:

- Employees must be insured for at least 12 months to be eligible to continue coverage.
- Portability is not available to employees who are no longer actively at work due to a disability, retirement, layoff or leave of absence.
- Premium rates are based on age and increase automatically in 5 year age bands, example 40-44 is one age band, at 45 the employee moves to the 45-49 age band.
- Employees may only elect to continue their current coverage or a lesser amount, and may not increase their benefit when porting coverage
- Employees may not Increase a benefit when porting coverage.
- Continued coverage may be cancelled by Chubb if the Employee:
  - fails to pay required premium within the policy's grace period for payment;
  - is rehired and becomes eligible under the group policy;
  - retires;
  - dies; or
  - remains unemployed from any occupation for 12 consecutive months.

What are the Employer's responsibilities?

- Fully Complete Section 1 of the request form and provide to the participant. Incomplete request forms may result in a denial to continue coverage.
- Determine if terminating employee is eligible to request portability.
- Provide separate request forms when portability is offered under more than one insurance policy.
- Provide premium rates and portability request form to eligible terminating employees.

What are the Employee's responsibilities?

- Fully Complete Section 2. Sign and date the request form. Incomplete request forms may result in a denial to continue coverage.
- Select the amount of coverage to be continued.
- Send the request form to the mailing or email address listed at the top of page 1, within the deadline to request portability.
- Please remember to sign and date this request form with today's date; and retain a copy of this for your records.

Individual Automatic Premium Collection Agreement and Authorization

CHUBB®

Employee Name: _____

Email: _____ Phone: _____

I, the individual who is signing below, hereby authorize Combined Insurance Company of America ("Combined"), a Chubb company, to initiate electronic debit entries or to effect a change by any other commercially accepted method, to my checking account (as shown below) in the financial institution named below (hereinafter called Depository). I specifically authorize Depository to debit my account on a monthly basis to pay premiums for the insurance for which I have applied today. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination. I understand that such notification from me must be given with sufficient time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it. I also authorize Combined to change the amount of my debit: (1) to correct clerical errors in the initial premium calculation for the selected coverage(s) and (2) to reflect changes in premium resulting from Combined's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my debit are to be made only at the direction of Combined and such change(s) does not require any other subsequent or additional authorization by me.

I understand that if premiums are not paid within the grace period under the subject policy(ies) or certificate(s), as in the event withdrawals are dishonored, the policy(ies) or certificate(s) will terminate. However, certain life insurance policies may contain non-forfeiture provisions and/or automatic premium loan provisions, which may extend coverage for a period of time. The specific provisions of each policy will govern.

Depositor Name: _____
(Please Print)

Depositor Signature: _____ _____
(Signature must be the same as on file at the bank/financial institution.) (Date)

Preferred draft date of each month: _____ Draft Amount: $ _____

TYPE OF COVERAGE	POLICY/CERTIFICATE NUMBER

Complete the information below or attach a voided check.

Name of Bank

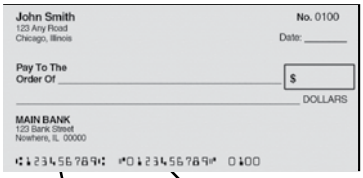
City & State of Bank

Routing (ABA) Number (9 digits)

Account Number

Account Type

☒ Checking



9 DIGIT ROUTING NUMBER

ACCOUNT NUMBER