HOSPITAL CASH PORTABILITY FORM

CHUBB®

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):

Date Coverage Ends (mm/dd/yyyy):

Fill in Current Requested Coverage for Each Insured

Insured Type	Hospital
Employee	☐ Plan 1 ☐ Plan 2 (if applicable)
Spouse	☐ Yes ☐ No
Child	☐ Yes ☐ No

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

Spouse Name: ☐ Continue Coverage ☐ Drop Coverage

Spouse Date of Birth (mm/dd/yyyy):

Spouse Social Security Number:

Child Coverage ☐ Continue Coverage
☐ Drop Coverage

Per your policy, child eligibility is subject to age limits.

Fill in Requested Coverage:

Insured Type	Hospital
Employee	☐ Continue Coverage ☐ 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 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 Hospital Cash policy under which this coverage is being offered, and is subject to satisfaction of the conditions provided therein.

Once a request 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.

Signature:

Today's Date (mm/dd/yyyy):

Email Address:

Please remember to complete and send in your beneficiary designation with this application. Please retain a copy for your records.

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PORTABILITY BENEFICIARY DESIGNATION FORM

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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

Policy Number

Division

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 _____ _____

Signature **Date**

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Important Information When Considering Portability Coverage

When your Hospital Cash insurance coverage ends, either because your employment has terminated or you are no longer eligible to participate in your employer's hospital 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 hospital policy. Some key considerations are:

Important facts to remember

- Portability is not available to employees who are no longer actively at work due to a disability, retirement, layoff or leave of absence.
- Portability allows you, your spouse or child(ren) to continue (or "port") Accident coverage at group rates.
- The ported coverage will be subject to the same provisions contained in your employer's Group Accident insurance policy.
- Employees may only request to continue their current coverage.
- Employees may not increase a benefit when porting coverage.
- Continued coverage may be canceled 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, or
    - dies.

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 apply for portability of Accident Insurance.
- Provide separate requests forms when portability is offered under more than one insurance policy.
- Provide premium rates and portability request forms 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

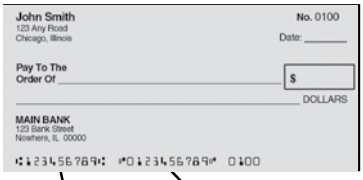
City & State of Bank

Routing (ABA) Number (9 digits)

Account Number

Account Type

☐ Checking



9 DIGIT ROUTING NUMBER

ACCOUNT NUMBER