Lifestyle Protection℠ Voluntary LTD Portability Application

First Unum Life Insurance Company
Portland, Maine 04122

Mail To: First Unum Life Insurance Company
Portability Unit
2211 Congress Street
Portland, Maine 04122

To Be Completed By Employer

Date	Portability Number	Current Premium Payment
__ __/__ __/__ __ __ __	**498449-0001**	

Employer (Firm Name and Division)

Address (Street, City, State, Zip)

Date of Termination	Last Day of Coverage	Employee's basic monthly earnings at time of termination	Employee's Occupation at time of termination
__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	$__________	

Reason for Employee termination:

Is employee terminating employment as a result of retirement, leave of absence, injury or sickness?
☐ Yes ☐ No

If yes, the employee is **not** eligible for coverage under the terms of the contract.

Employer Representative Signature	Plan Number

To Be Completed By The Employee

You may be eligible for continuation of your Lifestyle Group Long Term Disability Insurance. If you wish to exercise your Portability Privilege, please provide First Unum with the following information.

Name (Last, First, Middle Initial)	Sex	Social Security Number
	☐ M ☐ F	

Home Address (Street, City, State, Zip)	Date of Birth
	__ __/__ __/__ __ __ __

Are you enrolled or eligible to enroll for any other Group Long Term Disability coverage?

☐ Yes ☐ No

If you are approved for Portability, the Lifestyle Protection Plan Coverage will cease when the first of the following occurs:
a. the date you fail to pay the required premium;
b. the date you retire;
c. the date the policy terminates;
d. the date you become insured for Long Term Disability insurance under any other group long term disability income plan.

If you wish to apply for this coverage you must submit this completed application to First Unum's Home Office. If the application is not received by First Unum within **31 days** after termination of employment you will be ineligible to apply. Upon approval of this application a letter confirming coverage and a quarterly billing statement will be sent directly to you at the address provided.

Employee's Signature	Date
	__ __/__ __/__ __ __ __

Original — First Unum, Copy — Employee