Underwritten by
Union Security Insurance Company
Kansas City, MO

Election of Portability Coverage
Instructions & Application

If your coverage includes a Portability provision, you may continue your disability coverage for up to 12 months if your employment ends.

Please refer to your certificate of coverage for details regarding coverage amount, limitations and your eligibility to port.

You may not add or increase any amounts of coverage once you are eligible for or elect portability.

In order to continue your coverage, you must apply in writing and pay the first premium to us within 31 days after the date your employment ends.

***INSTRUCTIONS*:** To continue your disability coverage, you must do the following:

- Mail the original of completed application to: **Administrative Systems, Inc. (ASI)**
  111 Queen Anne Avenue North, Suite 200
  Seattle, WA 98109-4955
- or fax to ASI at **1-(206) 343-4587**
- Keep a copy for your records
- Upon approval, you will receive a bill from ASI. Monthly bills will be mailed to your home mailing address.

If you have any questions when completing this form, please call Toll-Free 1-(800) 877-2701 x250.

ELECTION OF PORTABILITY COVERAGE

APPLICATION TO CONTINUE DISABILITY INCOME INSURANCE

☐ **Group Short-Term Disability Income Coverage**
☐ **Group Long-Term Disability Income Coverage**

To be completed by the Employee - Please type or print all information

1. Name of Insured_____ (Last name / First name / Middle Initial)		2. Gender ☐ Male ☐ Female
3. Social Security Number:	4. Daytime phone number ( )	5. Date of Birth
6. Mailing Address (Street / City / State / Zip Code)		
7. Application is being made according to the Portability provision of Group Policy No./Participation No. _____ issued to: _____ (Legal name of Employer) _____ (Address of Employer) _____ _____ (Phone number of Employer)	8. Reason for requesting Portability coverage: My employment terminated on _____/_____/_____ (Month / Day / Year) Reason for terminating employment: ☐ Self-Initiated ☐ Retirement ☐ Labor Strike ☐ Lay Off ☐ Leave of Absence ☐ Other (explain)_____	
9. Are you disabled from a sickness or injury? ☐ Yes ☐ No	10. Annual Salary: (During the 12 months just prior to the date of this application - for this employer only) $ _____	

11. Are you covered for any other Disability Income Insurance other than item #7? ☐ Yes ☐ No

If yes, please provide name of insurer _____
and policy type: ☐ Individual ☐ Group ☐ STD ☐ LTD
You are not eligible for the Portability Coverage if you have other group disability insurance.

FRAUD NOTICES

Unless specific state language is provided below, and except for Virginia residents, the following general fraud notice applies: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Florida and Oklahoma residents: *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.*

Ohio residents: *Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

New Jersey residents: *Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.*

New York Residents: *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation***.**

The statements set forth above are true to the best of my knowledge and belief, and may be relied upon by Union Security Insurance Company in considering this application. Further, my signature below acknowledges that I have made a copy of my statements as they appear on this application.

Signature of Applicant_____ Date_____