

# Lewisville ISD

## Exit Package: What Happens to Benefits when you Leave the District?



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The information on the following pages contains information and forms to assist with continuing eligible benefits when you are leaving employment with Lewisville ISD. Some of these benefits are “**portable/convertible**” and some are covered by “**COBRA.**”

**PORTABLE** means that you can choose to pay the premiums directly to the contracted vendor and continue these benefits for you and your family members (if applicable). **CONVERTIBLE** means it may not be eligible for portability, and you will need to convert your coverage. A flyer is attached explaining these differences.

**COBRA** is a U.S. Congress-passed Bill called Consolidated Omnibus Budget Reconciliation Act of 1985. The health benefit provisions of the law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated. COBRA contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates.

**Group health coverage for COBRA** participants is generally more expensive than health coverage for employees, since usually the employer pays a part of the premium for active employees while COBRA participants typically pay the entire premium themselves. It is ordinarily less expensive than individual health coverage.

# Lewisville ISD Supplemental Benefits

PLAN	VENDOR INFO	COBRA/PORTABILITY/CONVERTIBLE	WHAT HAPPENS NEXT?
Medical	TRS 866.355.5999	COBRA	You will receive a letter from Bswift
Vision	MetLife 800.638.3120	COBRA	You will receive a COBRA packet from NBS after your term date
Dental	Cigna 800.244.6224	COBRA	You will receive a COBRA packet from NBS after your term date
Disability Plan	New York Life 888.842.4462	N/A	Coverage ends the date of your benefits termination with the district
Term Life and AD&D	CHUBB 888.499.0425	Portability & Convertible	For portability/conversion options you MUST contact CHUBB directly.
Legal Plan	Legal EASE 800-562-2929	Portability	You must call Legal EASE within 31 days to setup auto-payment
Critical Illness	Cigna 800.754.3207	Portability	Complete and return the attached portability form within 31 days to address on the form
Hospital Cash Plan	CHUBB 888.499.0425	Portability	Complete and return the attached portability form within 31 days to address on the form
Individual Life Insurance	Texas Life 800-283-9233	Portability	Fill out the attached forms and mail to Texas Life within 31 days
Emergency Ambulance Service	MASA 800.423.3226	Portability	Reach out to MASA for portability options
Retirement Savings	TCG Administrators 800.943.9179	You can no longer contribute, but it is your money/account	Your account will continue to be invested
Flexible Spending Accounts (FSA)	NBS 855.399.3035	COBRA	You will receive a COBRA packet from NBS after your term date
Health Savings Account (HSA)	EECU 817.882.0800	You can no longer contribute, But it is your money/account	Your account will continue to be invested
Telehealth + Behavioral Health	MDLIVE 888.365.1663	Portability	Contact MDLIVE for individual rate and set up an individual plan



## TRS Medical

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### TRS Medical is convertible to COBRA

TRS ActiveCare members are eligible for COBRA. The TRS ActiveCare COBRA Administrator at BSwift will send you a letter to your home via USPS to explain your options. If, after 45 days of leaving the district, you have not received information from BSwift, please call 833.682.8972.

## Dental and Vision Plans

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### Dental and Vision are convertible to COBRA

Like TRS ActiveCare above, your MetLife Vision and Cigna Dental are COBRA eligible. The Dental and Vision COBRA are administered through National Benefits Services (NBS). NBS, the COBRA Administrator, will send you a letter to explain your COBRA options and a payment coupon book after your separation from LISD. If after 45 days of leaving the district, you have not received information from National Benefit Services, please contact LISD at 469.948.8104 or by email at [benefits@lisd.net](mailto:benefits@lisd.net)

## Term Life and AD&D Plan by CHUBB

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You may retain your CHUBB Life insurance coverage after your benefit term ends. However, eligibility to continue coverage depends on the type of product you have. Some products may be eligible for portability while others may only be eligible for conversion. **After your benefit term date**, you will receive a letter from CHUBB outlining your specific options. If you have any questions about portability or are interested in conversion, **please call or email CHUBB at 888.499.0425 or CWBPortabilityConversion@CHUBB.com within 31 days from date of letter, you MUST reach out to CHUBB if interested in continuing coverage.**

## Legal Assistance Plan

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### Legal Plan by LegalEASE

You may continue your legal insurance by converting to an individual plan. Simply contact LegalEase within 31 days of your separation from employment to make payment arrangements. **You can contact LegalEase by calling 888.416.4313**

# Flexible Spending Account

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## FSA is convertible to COBRA

FSA Cobra is only available if the participant has unused funds and continues to contribute to the account during the plan year. If a participant leaves the district at the end of the plan year—the account ends, and no new elections can be made. For example, your termination date is 8/31 and you currently have a flex spending account that also ends 8/31, you cannot start a new account effective 9/1; or if your last day is 7/30, and your flex account ends 8/31 and you have funds left, you can contribute the final month of payments and use their account through 8/31. Keep in mind: It is a “use it or lose it” account.

# FICA, 457 and 403(b) Retirement Savings

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## Retirement savings accounts continue to be invested

Separation from employment is a qualifying event and thus allows you to remove your funds from your account if you wish. If you choose to keep your funds in your Retirement Savings Account, they will continue to be invested. You can also contact your Investment Provider directly to inquire about other investment options they offer.

# Health Savings Account (HSA)

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## Health Savings Account continue to be invested

Once you have established an HSA it is yours regardless of employment. Once you reach age 65 your funds can be withdrawn at any time and are only subject to ordinary income tax. However, you may avoid any tax by continuing to use the funds for qualified medical expenses. For those over age 65 premiums for Medicare Part A or B, Medicare HMO and employee premiums for employer sponsored health insurance can be paid from an HSA. For those electing COBRA Continuation Coverage your premium payments may also be paid from an HSA.

# Critical Illness Plan

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## Critical Illness Plan by Cigna

You may continue your Critical Illness plan by porting your coverage. There are eligibility rules you must meet to port your coverage, please contact Cigna customer service at 800-754-3207 for assistance. Once you have confirmed you are eligible to complete the attached Cigna portability application within 31 days of your separation from employment. Your employer will need to complete employer section 1 and the employee will need to complete the rest of the document and sign it. Return the completed form to: **Cigna Supplemental Health Solutions, P.O. Box 182201, Chattanooga, TN 37422.**



# Hospital Cash Plan

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## Hospital Cash Plan by CHUBB

You may continue this Hospital Cash Plan by porting your coverage. You will need to have your employer complete section 1, and the employee needs to complete the rest of the attached application within 31 days for separation from employment. Once completed return form one of two ways by mail to: **CHUBB P.O. Box 6703, Scranton, PA 18505-0703** or via email: **CWBPortabilityConversion@CHUBB.com** If you have questions, call CHUBB directly 888.499.0425.

# Individual Life Insurance

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## Individual Life by Texas Life Insurance

The rate of the individual life insurance you purchased is guaranteed to remain the same to age 100—and the policy remains intact until age 120. This policy is intended to provide coverage until your death. With individual life insurance, the policy is portable—so, regardless of your employment status, a benefit will be provided as long as premiums have been paid, and the contract is in force when you die. The Request for Service forms must be filled out and submitted to Texas Life within 31 days of your separation of employment for you to retain your coverage. You can either mail the forms to: **Texas Life at PO Box 830, Waco, TX 76703, or call 800.283.9233.**

# Telehealth + Behavioral Health

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## Telehealth + Behavioral Health by MDLIVE

You may elect to keep the MDLIVE telehealth benefit, **please contact MDLIVE directly at 888-365-1663** to speak with them about getting individual rate information and set up an individual plan.

# Emergency Ambulance Service

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## Emergency Ambulance Service by MASA Assist

Moving this plan from payroll deduction to automatic bank withdrawal is easy. **Simply call 800.643.9023 or visit [www.masaassist.com](http://www.masaassist.com)** and request the option to pay monthly with a credit card.



# Keep your life insurance active even if your employment status changes

Chubb makes it easy to keep your coverage so you can continue to protect what matters most.



You purchased Life Insurance with Accidental Death and Dismemberment (AD&D) to better protect your family from the financial hardships that can come if you are no longer around to support them. Stay protected. Keep your life insurance active by electing portability or conversion.

## Step 1: Explore your options for keeping your Life and Accidental Death and Dismemberment coverage



If your employment status changes, you have the option to continue your Life and/or AD&D coverage through portability or conversion. **Here's the difference:**

### Porting your Life and/or AD&D policy

This option allows you to continue your current Life and AD&D coverage at your current rate.

OR

### Converting your Life policy

This option allows you to convert your Life coverage to an individual permanent life insurance policy. AD&D is not available for conversion.

## Step 2: Review qualifying events for continuing your coverage



PORT ELIGIBLE	CONVERSION ELIGIBLE	EMPLOYMENT STATUS CHANGE
Yes ✓	Yes ✓	Retirement
Yes ✓	Yes ✓	Employment termination
Yes ✓	Yes ✓	No longer benefit eligible (reduced working hours don't meet benefit requirements)
No ✗	Yes ✓	Illness or injury prevents your ability to work
No ✗	Yes ✓	Employer cancellation of the group policy or Chubb modifications change eligibility
No ✗	Yes ✓	Covered child ages out of dependent status

## Step 3: Complete the portability or conversion form



### Portability

Complete and return the portability form provided by your employer, as instructed. Payment is required for the first two months of premium.

### Conversion

Call **1-888-499-0425** or email **CWBPortabilityConversion@Chubb.com** to request an Individual Life Insurance Conversion quote. Rates are subject to change when converting from a group to an individual policy.

If you choose to accept the Life Conversion quote for individual life insurance you'll be sent an application to sign and return with initial payment of premium.\*

## We'll take it from there

Our team will review the portability application. If approved, you will receive a confirmation of coverage letter and certificate. If you are not eligible for portability, you'll receive a letter of explanation and instruction for conversion, if eligible.

**Note:** Please refer to your policy certificate for specific portability and conversion provisions.

**For questions, please contact us at [CWBPortabilityConversion@Chubb.com](mailto:CWBPortabilityConversion@Chubb.com) or call 888-499-0425**



## Powered by Chubb

**A++**

Highly rated by AM Best Rating

**54**

Operating in 54 countries

**Leader**

Chubb is a world-leader in insurance

NEARLY

**\$17 billion**

paid out in claims every year

\*You have 31 days from the date of your loss of coverage to apply for portability or conversion. If your application is received in our office after 31 days, portability or conversion may be denied.

# Application for Portability of Critical Illness Insurance



**NEW YORK FRAUD WARNING:** 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 shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

For residents of the following states, please see the last page of this form: **California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas or Virginia.**

**Please use this form to submit your request to continue coverage under the Portability Provision of the Policy. Please complete the form and don't forget to include your Social Security Number, your Birthdate, and to sign your name and enter today's date.**

Return completed form to: Cigna Supplemental Health Solutions  
PO Box 182201  
Chattanooga, TN 37422

## EMPLOYER USE SECTION – TO BE COMPLETED BY THE EMPLOYER

*Please be sure to complete all items.*

Employer \_\_\_\_\_ Policy # \_\_\_\_\_  
Employee Name \_\_\_\_\_ Class \_\_\_\_\_  
Date Notice Completed \_\_\_\_\_ Date Notice Provided to Employee \_\_\_\_\_  
Employee's Coverage Effective Date \_\_\_\_\_ Spouse or Domestic Partner's Coverage Effective Date \_\_\_\_\_  
Child(ren)'s Coverage Effective Date \_\_\_\_\_ Type of Coverage:  Basic  Voluntary  
Critical Illness Coverage in Force on Employee's Last Day Worked (if no coverage in force, enter \$0):  
Employee \_\_\_\_\_ Spouse or Domestic Partner \_\_\_\_\_ Child(ren) \_\_\_\_\_  
Employment Category  Full-Time  Part-Time  
Date of Hire \_\_\_\_\_ Last Day Worked \_\_\_\_\_ Coverage Termination Date \_\_\_\_\_  
Employment Termination Date \_\_\_\_\_  
Reason to Initiate  Change to another Class  Inactive  Leave of Absence  Strike  Termination  
Portability:  End of Continuation Provision  Layoff  Military Service  Retirement  
Employer Signature \_\_\_\_\_ Date \_\_\_\_\_

**Note to Employer: Be sure to check the group policy regarding portability limitations.**

## EMPLOYEE INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
Have you smoked or used any form of tobacco in the past 12 months?  Yes  No

## SPOUSE OR DOMESTIC PARTNER INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender  Male  Female  
Has your Spouse or Domestic Partner smoked or used any form of tobacco in the past 12 months?  Yes  No  
Do you wish to continue Critical Illness coverage for your Spouse or Domestic Partner?  Yes  No

**Note: Coverage may be continued on your Spouse or Domestic Partner only if you had coverage for them while you were actively employed.**

**Please turn to other side to complete form. Be sure to make a copy for your records.**

Employee Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

### CHILD(REN) INFORMATION

Do you wish to continue Critical Illness coverage for your dependent child(ren)?  Yes  No

How many children are you covering? \_\_\_\_\_

**Note: Coverage may be continued on your dependent child(ren) only if you had coverage for them while you were actively employed.**

### GENERAL INFORMATION

- Eligibility** – You must be covered under the policy for the required amount of time and cannot be above the maximum age to continue your coverage. If you do not meet these requirements you will not be eligible to continue your coverage. These limitations may be reviewed in your Certificate.
- Rates** – You will continue with group rates, but rates may be subject to change.
- Deadline** – You have 31 days from the date coverage ended to exercise the portability option. Mail or fax your completed form promptly.
- Effective Date** – Your ported insurance will become effective on the date your insurance would otherwise have terminated, if you have applied and agreed to pay required premiums within 31 days of the date you would otherwise have ceased to be eligible.
- Coverage Changes** – If you have any questions on how to make changes to this coverage, please contact our Customer Service Center at 1-800-754-3207 for assistance.
- Billing** – You will be billed on a quarterly basis; however, your initial bill may be for a shorter or longer period of time for billing cycle reasons. After the initial bill, you will receive your bill approximately 30 days in advance of the due date. In order to keep your coverage in force, you must pay your premiums promptly.

### SIGNATURE

If this form is signed by an agent, such as an attorney-in-fact, conservator or guardian, a copy of the document conferring the power of the agent to sign must accompany this form (e.g., power of attorney, guardianship papers, etc.).

#### Please Sign Here



Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Complete this form, sign and date, and return to:**

**Cigna Supplemental Health Solutions, P.O. Box 182201, Chattanooga TN 37422 or by fax to 1-866-304-4323.**

**Do not return this form to your employer.**

**For questions, please contact our Service Center toll-free at 1-800-754-3207, Monday through Friday 8 a.m. to 8 p.m. Eastern Time**

Accidental Injury, Critical Illness, and Hospital Care plans or insurance policies are distributed exclusively by or through operating subsidiaries of Cigna Corporation, are administered by Cigna Health and Life Insurance Company, and are insured by either (i) Cigna Health and Life Insurance Company (Bloomfield, CT); (ii) Life Insurance Company of North America ("LINA") (Philadelphia, PA); or (iii) New York Life Group Insurance Company of NY ("NYLGICNY") (New York, NY), formerly known as Cigna Life Insurance Company of New York. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. LINA and NYLGICNY are not affiliates of Cigna.

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## IMPORTANT CLAIM NOTICE

**California Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** 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.

**Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota Residents:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Oregon Residents:** Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

**Pennsylvania 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Rhode Island Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Texas Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Virginia Residents:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

**HOSPITAL CASH PORTABILITY FORM**



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
		<input type="text"/>	<input type="text"/>
Employee Name (Last, First, MI):	Effective Coverage Ends (mm/dd/yyyy):		

**Fill in Current Requested Coverage for Each Insured**

Insured Type	Hospital
Employee	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 (if applicable)
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Spouse Name: <input type="checkbox"/> Continue Coverage <input type="checkbox"/> 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	<input type="checkbox"/> Continue Coverage <input type="checkbox"/> 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.

# CHUBB® PORTABILITY BENEFICIARY DESIGNATION FORM

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

**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.

<b>PART 1: Information About You</b>											
Name (Last Name, Suffix, First Name, MI)	Social Security Number <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Policy Number	Division <table border="1" style="width: 60px; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 60px;"></td> </tr> </table>										

<b>PART 2: Primary Beneficiary (ies)</b>					
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%					

<b>PART 3: Contingent Beneficiary (ies)</b>					
If <b>all</b> 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%					

<b>PART 4: Signature</b>
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**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Signature Date

## 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.

**This product is underwritten by ACE Property & Casualty Insurance Company and Combined Insurance Company of America, Chubb companies. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. Refer to your Certificate of Insurance for specific details about benefits, exclusions and limitations.**

Individual Automatic Premium Collection  
Agreement and Authorization



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

Preferred draft date of each month:

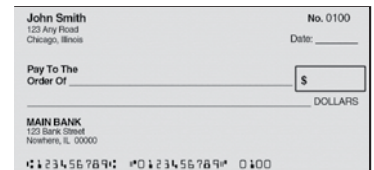
Draft Amount \$

TYPE OF COVERAGE


POLICY/CERTIFICATE NUMBER


Complete the information below or attach a voided check.

<b>Name of Bank</b>	<input type="text"/>
<b>City &amp; State of Bank</b>	<input type="text"/>
<b>Routing (ABA) Number (9 digits)</b>	<input type="text"/>
<b>Account Number</b>	<input type="text"/>
<b>Account Type</b>	<input type="checkbox"/> Checking



9 DIGIT ROUTING NUMBER

ACCOUNT NUMBER

Contract Number: \_\_\_\_\_

Insured Name: \_\_\_\_\_

**INSTRUCTIONS:** Use this form to request a full surrender and termination of your life insurance contract with the Company. The owner of this contract assigns the contract to the Company and acknowledges that any loan on this contract is a first lien and shall be deducted from the Cash Value. The owner declares that there are no proceedings of insolvency or bankruptcy against him or her and that no other person, firm or corporation has any interest in said contract except the owner. To process your request the Company must receive BOTH pages of this form in our office and the form must be satisfactorily completed. The Company will accept the form by fax, mail, or email. See **'How To Submit This Form'** on Page 2.

**ABOUT THE CONTRACT OWNER:****If Individual:**

Owner Name _____	Owner Social Security Number _____
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Phone Number _____	E-Mail Address _____
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**If Trust or Business Entity:**

Print Full Name of Trust/Business Entity _____	Date Trust Executed (mm/dd/yyyy) _____
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Tax ID No. of Trust/Business Entity _____	Phone Number _____	E-Mail Address _____
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Contact Person - Full Name _____	Title _____
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**Full surrender, termination and payment**

I request a full surrender and termination of the life insurance contract listed above and request payment of the proceeds.

**Please provide the address where your check should be mailed:**

Street Address _____	City _____	State _____	Zip _____
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Should we use this address for all future correspondence with you?  Yes  No**Lost Contract Statement:**

If the original contract is not enclosed with this request, the owner of this contract certifies the above contract has been lost or destroyed and agrees to return the original contract to the Company, without claim, should it be found.

**About Income Tax Withholding**

Under current federal income tax law, we are required to withhold 10% of the taxable portion of the cash surrender value and pay it to the IRS unless you tell us in writing not to withhold tax. Some states also require us to withhold state income tax if we withhold federal tax.

You are responsible for paying income tax on the taxable portion of your payment even if we do not withhold taxes. In making your decision about withholding taxes, you should consider that penalties under the estimated income tax rules may apply if your withholding and estimated income tax payments are not sufficient.

**Please Check One:**  **Withhold**  **Do Not Withhold***(This choice is void if we do not have your Social Security Number or Tax ID Number)*

**CERTIFICATION:**

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number, and;
- 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and;

*(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*

- 3. I am a U.S. Citizen or other U.S. person, and;
- 4. I am not subject to Foreign Account Tax Compliance Act (FATCA) reporting because I am a U.S. person and the account is located within the United States.

*(If you are not a U.S. Citizen or other U.S. person, for tax purposes, please cross out the last two certifications and complete appropriate IRS documentation.)*

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

**Florida Residents - Review the statement below and check if applicable:**

- Check this box if your insurance agent recommended (advised) you to surrender your life insurance contract and the surrender proceeds will NOT be used to fund or purchase another life insurance contract or annuity contract.
  - The state of Florida requires that we first provide you with important disclosure information.
  - We are unable to send your surrender proceeds via EFT or wire. We will promptly send you a check.
  - Provide an E-Mail address or fax number in the space provided below so we can send the important disclosure information to you.

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Fax Number

**SIGNATURE(S):** The request for cash surrender must be dated current. The signature of the contract owner must be written exactly as the name appears in the contract or any subsequent endorsements to the contract.

**If Individual:**

\_\_\_\_\_  
Signature of Contract Owner

\_\_\_\_\_  
Date

**If Trust or Business Entity:**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Full Name

\_\_\_\_\_  
Title

**HOW TO SUBMIT THIS FORM:**

**MAIL:**

Texas Life  
P. O. Box 830  
Waco, TX 76703-0830

**FAX:**

254-745-6393

**E-MAIL:**

customerservice@texaslife.com

## Automatic Bank Draft Form

*A convenient payment option for you...*

### Three Easy Steps:

1. Read and complete each item on the Automatic Bank Draft Form.
2. Include either a voided check or deposit slip or provide bank information below.
3. Include any payments due.

Please enter all Texas Life Insurance Company contract numbers you want drafted with this authorization: \_\_\_\_\_

Texas Life will begin drafting your account for the current or any outstanding premiums due immediately upon receipt of this form. The premium(s) will be drafted on the contract due date(s).

Bank Name: \_\_\_\_\_ Please check appropriate box:

Account Holder Name: \_\_\_\_\_  Checking

Routing #: \_\_\_\_\_  Savings

Account #: \_\_\_\_\_ **OR** include a voided check or deposit slip

Contact information:

Cell Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Drafts are submitted to the bank on the day your form is received, if past due. Drafts should clear your account within 2 - 3 days. If your draft date falls on a weekend or holiday, it will leave our office on the next business day.

*As a convenience to me, I hereby request and authorize you to pay and charge to my account drafts drawn on my account by and payable to the Texas Life Insurance Company, Waco, Texas provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such draft shall be the same as if it were a draft drawn on you and signed personally by me. The payment of premium under this plan may be discontinued by the Company or the under-signed. You shall be under no obligation to determine the correctness of the amount of any draft drawn under this authority. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. For the purpose of this form, a facsimile copy of my signature shall be as valid as an original. (Fax (254)745-6393)*

\_\_\_\_\_  
**Signature of Bank Account Holder**

\_\_\_\_\_  
**Date**