Lewisville ISD

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



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Revised 10-2026

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 – Continues your benefit under the group policy, not an individual one. Premiums may change. Not available if you or a dependent has a condition materially affecting life expectancy. **CONVERTIBL**E – Moves coverage to an individual policy you own outright. Premiums are higher, but not subject to the group policy's reduction schedule.

COBRA is a U.S. Congress-passed Bill called Consolidated Omnibus Budget Reconciliation Act of 1985. The health benefit provisions of the law amend 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.

Lewisville ISD Supplemental Benefits

PLAN	VENDOR INFO	COBRA/PORTABLE/CONVERTIBLE	WHAT HAPPENS NEXT?
Medical	BCBSTX 866.355.5999	bswift – COBRA 833.682.8972	You will receive a COBRA packet in the mail from bswift after your term date. Enroll within 60 days of loss of coverage date. TRS Retirees – See note on page 3
Vision	EyeMed 888.581.3648	NBS – COBRA 800.274.0503	You will receive a COBRA packet in the mail from NBS after your term date. Enroll within 60 days of loss of coverage date.
Dental	Cigna 800.244.6224	NBS – COBRA 800.274.0503	You will receive a COBRA packet in the mail from NBS after your term date. Enroll within 60 days of loss of coverage 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	**Portable & Convertible depending on product**	You will receive a letter in the mail from CHUBB after your benefits term date. You must respond within 31 days of date on letter.
Legal Plan	Legal EASE 800.248.9000	**Portable**	You must call LegalEASE within 31 days.
Critical Illness	Cigna 800.754.3207	**Portable**	Complete and return the attached portability form within 31 days.
Hospital Cash Plan	CHUBB 888.499.0425	**Portable**	If eligible, complete and return the attached portability form within 31 days.
Individual Life Insurance	Texas Life 800.283.9233	**Portable**	Contact Texas Life within 31 days.
Emergency Ambulance Service	MASA 954.820.4332	**Portable**	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 eligibility depends on benefit term date	You may receive a COBRA packet from NBS after your benefit term date if you have unused funds and the benefit terms before end of plan year.
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 open and available.
Telehealth + Behavioral Health	Recuro Health 855.673.2876	**Portable**	Contact Recuro for individual rate and set up an individual plan.

TRS Medical

TRS Medical is convertible to COBRA – Enroll within 60 days of loss of coverage date

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.**

TRS Retirees enrolling in TRS Care: TRS Care must start **after** your TRS ActiveCare plan ends. You cannot be concurrently enrolled in both plans per TRS rules. Contact the LISD Benefits Dept at 469.948.8104 if you do not know when your TRS ActiveCare plan ends upon termination of active employment.

Dental and Vision Plans

Dental and Vision are convertible to COBRA – Enroll within 60 days of loss of coverage date

Your EyeMed 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 NBS at 800.274.0503.**

Term Life and AD&D Plan by CHUBB

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 and you must respond within 31 days of the date of letter. 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.**

Legal Assistance Plan

Legal Plan by LegalEASE

You may continue your legal plan coverage by converting it to an individual plan. Simply contact LegalEase within 31 days of your benefits termination date to make payment arrangements. **You can contact LegalEase by calling 800.248.9000.**

Flexible Spending Account

FSA may be convertible to COBRA – If eligible, enroll within 60 days of loss of coverage date

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's account terminates at the end of the plan year, the account ends and no new elections can be made. For example, if your benefit termination date is 8/31 and you currently have a flex spending account that also ends 8/31, you cannot convert to COBRA. However, if your last day is 4/30, and you have funds left, you can continue to contribute the monthly amount and use the account through 8/31 through COBRA. Keep in mind: It is a "use it or lose it" account. **Contact NBS COBRA at 800.274.0503 with questions specific to your account.**

FICA, 457 and 403(b) Retirement Savings

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. **Contact TCG Administrators with additional questions at 800.943.9179.**

Health Savings Account (HSA)

Health Savings Account will continue to be open and funds available

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. **Contact EECU at 817.882.0800 with questions about your account.**

Critical Illness Plan

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, 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 or follow Cigna's instructions for returning the application.**

Hospital Cash Plan

Hospital Cash Plan by CHUBB

You may continue the Hospital Cash Plan by porting your coverage. Portability is not available to employees who are no longer actively at work due to disability, retirement, layoff or leave of absence. 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 from separation of employment. Return the form by mail to: CHUBB P.O. Box 6703, Scranton, PA 18505-0703 or via email: CWBPortabilityConversion@CHUBB.com, or follow CHUBB's instructions. **If you have questions, call CHUBB directly 888.499.0425.**

Individual Life Insurance

Individual Life by Texas Life Insurance

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. Contact Texas Life within 31 days of your benefit termination date to retain your coverage. **Call Texas Life at 800.283.9233 for more information.**

Telehealth + Behavioral Health

Telehealth + Behavioral Health by Recuro Health

You may choose to keep the Recuro telehealth benefit by setting up an individual plan. **Contact Recuro directly at 855.673.2876.**

Emergency Ambulance Service

Emergency Ambulance Service by MASA MTS

Moving this plan from your employer to an individual plan is easy. **Simply call MASA at 954.820.4332.**

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 Portability: ☐ Change to another Class ☐ Inactive ☐ Leave of Absence ☐ Strike ☐ Termination ☐ 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

1. **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.
2. **Rates** – You will continue with group rates, but rates may be subject to change.
3. **Deadline** – You have 31 days from the date coverage ended to exercise the portability option. Mail or fax your completed form promptly.
4. **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.
5. **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.
6. **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

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	ivision	Class

Employee Name (Last, First, MI):	ate 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:	ate 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.

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.

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**

CHUBB®

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

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

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

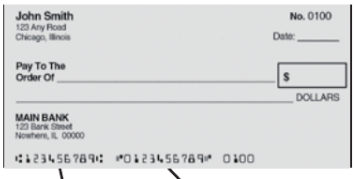
City & State of Bank

Routing (ABA) Number (9 digits)

Account Number

Account Type

☐ Checking



9 DIGIT ROUTING NUMBER

ACCOUNT NUMBER

TEXASLIFE INSURANCE COMPANY

REQUEST FOR CASH SURRENDER

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 _____

Phone Number _____ E-Mail Address _____

If Trust or Business Entity:

Print Full Name of Trust/Business Entity _____ Date Trust Executed (mm/dd/yyyy) _____

Tax ID No. of Trust/Business Entity _____ Phone Number _____ E-Mail Address _____

Contact Person - Full Name _____ Title _____

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 _____

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)

06I186 R06/20 **Both pages of this form must be returned**

Since 1901 | 900 WASHINGTON AVE | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830 | 800-283-9233 | 254-752-6521 | www.texaslife.com

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

TEXASLIFE INSURANCE COMPANY

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 undersigned. 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**

061016 R06/20

Since 1901 | 900 WASHINGTON AVE | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830 | 800-283-9233 | 254-752-6521 | www.texaslife.com