Guardian®

Optional Insurance
Election of Portability Coverage

Send this form to: National Conversion Department, P.O. Box 8070, Appleton, WI 54912-8070
Fax number: 920-749-6219
Secure E-mail: national_conversions@glic.com

Planholder Name (Company Name)		Group Plan No.	
Employee's Name (Last, First, MI)	Soc. Sec. No.	Birth Date / /	Sex ☐ M ☐ F
Employee's Home Address (Street, City, State, Zip)			
Home Telephone Number ( ) -	Work Telephone Number ( ) -	Date Employment Terminated / /	
Reason Employment Terminated			
Have You Applied or Will You Apply for the Extended Life Benefit under Your Employer's Plan?			

Please complete the following information for all dependents to be covered:

Spouse/domestic partner (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -	**Social Security Number** - -	**Sex** ☐ M ☐ F	**Birth Date** / /	**F/T Student**
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	- -	☐ M ☐ F	/ /	☐ Yes ☐ No
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	- -	☐ M ☐ F	/ /	☐ Yes ☐ No
Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	- -	☐ M ☐ F	/ /	☐ Yes ☐ No
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	- -	☐ M ☐ F	/ /	☐ Yes ☐ No

The following individuals are eligible to port the Life Insurance: the employee; the employee and his/her spouse/domestic partner; or the employee and all eligible dependents. Also, in the event of the employee's death, a surviving spouse/domestic partner under age 70 may port the coverage for him/herself and all eligible dependent children.

Please indicate whose coverage will be ported:

☐ Employee Only
☐ Employee and Spouse/domestic partner
☐ Employee and All Eligible Dependents
☐ Surviving Spouse/domestic partner
☐ Surviving Spouse/domestic partner and Child(ren)

The amount that is eligible to be ported is a dollar amount equal to:

Option A - The full amount of the inforce group term insurance; or
Option B - 50% of that amount (provided the ported amount is not less than $25,000 on the employee, $2,500 on the spouse/domestic partner and $1,000 on the child(ren).

Please indicate whether you elect Option A or Option B.

☐ Option A ☐ Option B

Please indicate your beneficiary designation:

Name of Beneficiary: Relationship

Address: Phone Number: ( ) -

Social Security Number: Birth Date: / /

The enclosed Premium Notice outlines the monthly premium rates for this coverage and the modes of payment.

For your insurance to remain inforce, we must receive your application within 31 days of your termination date of your employment.

Coverage is reduced by 35% at age 65. Coverage terminates at age 70.

Signature: _____ Date: _____

Keep a copy for your records