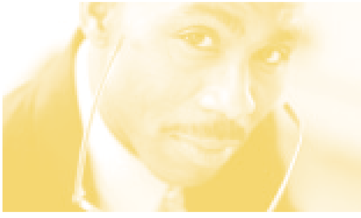
Portability



You can take your term life insurance with you.

This term life insurance is portable, up to the limits outlined in your certificate. This means if your coverage terminates because you terminate employment or eligibility, you can keep the group term life coverage you're currently paying for within the specified age and plan limits shown on the enclosed plan outline page. Please note: Term insurance provides a death benefit only; there is no cash value. Your certificate is issued without medical questions.

Eligibility

To be eligible, you must complete the enclosed Request for Portability of Group Term Life Insurance application and return it with the first premium payment within 31 days following the date of your termination of coverage. You are not eligible if you are both disabled and away from work on this date. You and your dependents are eligible for portable term insurance if you and your dependents are covered for term life insurance with a portability feature under your employer's group plan on the day before your coverage terminated. Administration of your portable coverage is continued on a direct bill basis through Aetna.

Note: If you select this option, your premium rate will be different than the rate you paid for your coverage as an active employee.

Say Yes! Let us know you want to take it with you!

It's easy! Act now by completing and returning the enclosed forms.

Remember: Your completed application and first payment must be received within 31 days of the date your coverage terminated.

Portability Option for Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Read This Instruction Page Carefully.

Instructions

1. Employer

Please Print

- Complete the "Portability Option for Group Term Life Insurance" portion of the booklet (left side) in its entirety. **Do not separate the booklet along the perforation**.
- Be sure that:
  - Both copies are legible. Please bear down to make clear copies.
  - All items are completed.
  - The form is signed by your authorized representative.
- Return the booklet to your employee to complete the "Request for Portability of Group Term Life Insurance" portion (right side).

2. Employee

Please read the Fraud Notice on the back of the form, before completing.

Please Print

- Complete the "Request for Portability of Group Term Life Insurance" portion of the booklet (right side) in its entirety. **Do not separate the booklet along the perforation**.
  - Consult the Rate Tables and instructions (included in the kit) to determine insurance amounts and costs. Note: If Rate Tables have expired, contact Aetna at 1-800-826-7448 to obtain the correct rates.
- Be sure that:
  - Both copies are legible. Please bear down to make clear copies.
  - All items are completed.
  - The form is signed by you.
- Keep the "Employee Copy" (second page) of both sides of the form for your records. Mail the "Aetna Copy" (first page) to:

  Aetna Life Insurance Company
  Group Insurance
  151 Farmington Avenue
  Hartford, CT 06156-7350

Please call Aetna's toll-free number if you have any questions about how to complete this form.

1-800-826-7448

Portability Option for Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Request for Portability and payment of the first premium due for the frequency chosen must be made within 31 days after the date your group insurance terminates.

Brief Description of Portability Feature

Subject to the terms of the Group Policy (as described in your group insurance certificate) the employee may apply for portability of Group Term Life Insurance for which the employee pays the entire cost (contributory insurance.) No medical examination is required, but the Request for Portability of Group Term Life Insurance and payment of the first premium for the frequency chosen must be made within 31 days of the date the Group Term Life Insurance terminates, and the employee must not be both disabled and away from work on that date.
Premiums must be paid annually, semi-annually, or quarterly by direct bill (nominal per bill fee).

Notice of Eligibility Statement - To be Completed by the Employer (Please Print)

1. Employer Name
2. Group Policy (Control) Number
3. Division Name (If Applicable)
4. Employee Name (First, Middle Initial, Last)
5. Employee Address
6. Employee Home Telephone Number ( ) -
7. Employee Social Security Number ☐☐☐-☐☐-☐☐☐☐
8. Was employee actively at work (i.e., not disabled and away from work due to illness or injury) on date of termination? ☐ Yes ☐ No
8a. Was termination due to retirement? ☐ Yes ☐ No
9. Date Contributory Term Life Insurance Terminated
10. Amount of Supplemental Term Life Coverage ____
10a. Amount of Basic Coverage ____
11. Annual Salary at Time of Termination ____
12. Was group plan a salary multiple schedule? ☐ Yes ☐ No
If "Yes", provide the following information:
a. Show salary schedule, i.e., 1X, 2X, 3X salary, etc. ____
b. Employee Selected Salary Multiple at Time of Termination: ____
c. Was salary multiple rounded? ☐ Yes ☐ No
If "Yes", indicate rounded amount: ____
13. Was insurance offered in "flat" amounts ($20,000, $25,000, $35,000, etc.)? If "Yes": ☐ Yes ☐ No
a. Provide "flat" amount schedule: ____
b. "Flat" amount selected by employee: ____
14. List Employee Most Recent Beneficiary Designation(s)

	Name (First, Middle Initial, Last)	Social Security Number	Birthdate (MM/DD/YYYY)	Relationship to Employee
a. Primary	____	☐☐☐-☐☐-☐☐☐☐	____	____
b. Contingent	____	☐☐☐-☐☐-☐☐☐☐	____	____

15. If contributory term life insurance is assigned, provide name, address and Social Security Number of assignee.
16. For dependent coverage, provide dependent names, relationship, amounts of coverage and Social Security Numbers.
17. Check other current benefit provisions employee has.
☐ Disability Benefit (Waiver of Premium) ☐ Accidental Death Amount ____ ☐ Other ____
☐ Accelerated Benefit Rider ☐ Accidental Death & Dismemberment Amount ____

Signature (Employer Authorized Representative) X ____ Date

Aetna Home Office Use Only

Date Portability Request Sent to Applicant	By CSR	Date Received	By CSR

Remarks

Request for Portability of Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Request for Portability and payment of the first premium due for the frequency chosen must be made within 31 days after the date your group insurance terminates.

I hereby apply for coverage in accordance with the portability provision of the group policy issued to ____________________________

Employee Coverage (Please Print)

1. Employee Name (First, Middle Initial, Last)

2. Sex ☐ Male ☐ Female

3. Birthdate (MM/DD/YYYY)

4. Residence (Number, Street, City, County, State, Zip Code)

5. Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

6. Telephone Numbers (Include Area Code) Home Work

7. Coverage Termination Date Month _________ Day ___ Year ______

8. Were you actively at work on your date of termination? ☐ Yes ☐ No
If "NO," please explain in Number 3 under "Other" (at bottom of page).
Actively at work means you were not disabled and away from work due to illness or injury on the date of termination.

9. Amount of Insurance Requested (Must not exceed amount of Group Term Life Insurance when coverage terminated and is subject to the limits described in your certificate.) $____________________

10. Other Benefits and Amounts (Check only the benefits you had at time of termination.)
☐ Accidental Death Amount $ ________________
☐ Disability Benefit (Waiver of Premium)

11. Have you (employee) used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months? ☐ Yes ☐ No

Spouse Coverage (Please Print)

1. Spouse Name (First, Middle Initial, Last)

2. Sex ☐ Male ☐ Female

3. Birthdate (MM/DD/YYYY)

4. Residence (Number, Street, City, County, State, Zip Code) If different than above employee only.

5. Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

6. Amount of Insurance Requested (Must not exceed **spouse** amount of Group Term Life Insurance for which the employee paid the entire cost when employee coverage terminated, and must not exceed amount of employee insurance. Subject to the limits described in the employee certificate.) $__________________

7. Other Benefits and Amounts (Check only the benefits you had at time of termination.)
☐ Accidental Death Amount $ ________________

8. Has spouse used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months? ☐ Yes ☐ No

Child Coverage - Provide Information on the Youngest Child Only (Please Print)

1. Child Name (First, Middle Initial, Last)

2. Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

3. Age

4. Birthdate (MM/DD/YYYY)

5. Sex ☐ Male ☐ Female

6. Amount of Insurance Requested (Must not exceed amount of **child** Group Term Life Insurance for which the employee paid the entire cost when employee coverage terminated, and must not exceed amount of employee insurance. Subject to the limits described in the employee certificate.) $ ______________

Beneficiary Information (Please Print)

Beneficiary(s) under Portable Group Term Life Insurance (If different than most recent designation reported to insurer by Employer. See Number 14 on the "Portability Option for Group Term Life Insurance" form.)

	Name (First, Middle Initial, Last)	Social Security Number	Birthdate (MM/DD/YYYY)	Relationship to Employee
1. Primary	______________________	☐☐☐ - ☐☐ - ☐☐☐☐	____________	______________
2. Contingent	______________________	☐☐☐ - ☐☐ - ☐☐☐☐	____________	______________

Beneficiary for the dependent coverage(s) applied for is the employee unless the coverage is assigned, in which case the assignee will be beneficiary.

Other (Please Print)

1. Premium Payable ☐ Annual ☐ Semi-annual ☐ Quarterly

2. Premium Amount Enclosed $ ____________________

3. Additional Information (Refer to specific section and question number.)

THE UNDERSIGNED UNDERSTANDS AND ACKNOWLEDGES THAT: (1) The statements and answers made herein are complete and true to the best of my knowledge and belief; (2) issuance of the portable coverage applied for shall be exchanged for all privileges and benefits under the Group Policy, including the conversion provision, with respect to the portability amount requested; (3) no person other than an officer of Aetna can make, modify, or discharge a contract or waive any of Aetna'srights or requirements; (4) no portable coverage will be effective unless this enrollment form and premium required have been made in accordance with the terms of the Group Policy; if not, any payment received will be refunded; (5) the effective date of portable coverage applied for will be 31 days following the group coverage termination date, otherwise known as the "portability date." If any balance due is not paid, any portable coverage provided will continue only for the period which the payment will purchase on a pro rata basis.

Signed at ______________________________ on __________________ **X** ______________________________
City, State Date Employee Signature

Privacy Notice

In evaluating your insurability, we rely primarily on the health information you furnish to us in this statement.

Disclosure of Information

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction, amendment or deletion of recorded personal information in states which provide such right and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Group Insurance
151 Farmington Avenue
Hartford, CT 06156-7350

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. 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.

Attention 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 a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to 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.

Attention Kentucky, Ohio and 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.

Attention Louisiana and West Virginia 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.

Attention Maine and 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 may include imprisonment, fines or a denial of insurance benefits.

Attention 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.

Attention 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 insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Client Information

Plan Sponsor:	Army & Air Force Exchange Service	Effective Date:	09/01/2000
Control Number:	750573	Contract State:	TX

Plan Specifics

Portability Benefit Limits	Minimum	Maximum	
Employee Coverage Limits:	$5,000	$500,000	Benefit amount must be in increments of $1,000. Benefit amount election cannot be less than plan minimum or exceed benefit amount in force prior to termination of employment or portability plan maximums.
Spouse Coverage Limits:	$1,000	$25,000	
Child Coverage Limits:	$1,000	$5,000	Coverage is available from birth to age 19, up to age 22 if full time unmarried student. It is the employees responsibility to notify Aetna when a child is no longer eligible. Coverage will be terminated when the last child reaches limiting age.

Current Benefit amounts in excess of Portability limits may be converted to a whole life policy

Age Reduction*

Employee Age Reduction: Coverage reduces to 65% of elected portability amount at age 65; to 40% of elected portability amount at age 70, and to 25% of elected portability amount at age 75; and ceases at age 99

Spouse Age Reduction: Coverage reduces to 0% of elected portability amount at age 65

Reduction takes place on January 1st of each year. The amount of the life insurance lost due to age reduction may be converted within 31 days to a whole life policy.

Coverage Changes

Increase Coverage Amounts: Increasing the amount of your coverage after termination of employment is not permitted.

Additions of Members/Benefits: Addition of members or coverage after termination of employment is not permitted.

Additional Information

No reinstatement of policy is permitted once the policy lapses.

In the event of employee death or divorce the spouse and child(ren) the coverage will cease.

Part Time employees only have conversion option

Monthly Rates

Monthly premium rates per $1000 of coverage for the Aetna Portable Group Term Plan.

Description: Premium rates are based upon your Issue Age when the portable coverage takes effect and will change annually when you cross age bands. Rates are provided for smokers and non-smokers. Select the appropriate smoker or non-smoker rates for your coverage, and your spouse's coverage, if applicable. A person who has not used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months is considered a non-smoker.

The rates included in the table below, were appropriate for the plan at the time they were prepared. The rates are subject to change without notice annually. You should confirm that the rates shown are for the current year. You may obtain current rates by calling Aetna at 1-800-826-7448. These rates do not include the billing fee, expected to be $2.00 per bill charged to the employee.

Monthly Rates - Employees and Spouse

Rates effective through December 31, 2005

Issue Age	Employee Non-Smoker	Employee Smoker	Spouse Non-Smoker	Spouse Smoker
15-19	$0.07	$0.11	$0.07	$0.11
20-24	$0.07	$0.11	$0.07	$0.11
25-29	$0.07	$0.11	$0.07	$0.11
30-34	$0.08	$0.12	$0.08	$0.12
35-39	$0.11	$0.16	$0.11	$0.16
40-44	$0.16	$0.24	$0.16	$0.24
45-49	$0.28	$0.40	$0.28	$0.40
50-54	$0.45	$0.66	$0.45	$0.66
55-59	$0.71	$1.02	$0.71	$1.02
60-64	$1.12	$1.62	$1.12	$1.62
65-69	$1.94	$2.81		
70-74	$3.41	$4.93		
75-79	$5.97	$8.63		
80-84	$10.45	$15.10		
85-89	$18.29	$26.43		
90-94	$32.01	$46.25		
95-99	$56.02	$80.94		

Monthly Rates - Dependent Child(ren)

$0.20 per thousand dollars of coverage

Portability for Group Term Life Benefit
Premium Calculation

The following payment arrangements are available to you on a direct-billed basis (bills will be mailed to your mailing address directly by Aetna): .
Annual (once per year)*, Semi-Annual (twice per year), and Quarterly (four times per year)*****

To calculate your premium cost estimate, use the appropriate age, coverage amount(s) and your selected premium payment arrangement.

	Employee Spouse Coverage	Example	Your Cost Estimate
1	Enter the amount of insurance requested on yourself.	$20,000	
2	Amount of insurance requested in #1 (above) divided by 1,000 equals:	20	
3	Enter the amount of insurance requested on your spouse.	$10,000	
4	Amount of insurance requested in #3 (above) divided by 1,000 equals:	10	
5	From Table 1, enter the Monthly premium rate (regardless of the payment arrangement you are selecting) which corresponds with your age and smoking status.	$0.13	
6	From Table 1, enter the Monthly premium rate which corresponds with your spouse's age and smoking status:	$0.11	
7	Multiply #5 by #2 . This is the monthly premium payable for you:	$2.60	
8	Multiply #6 by #4. This is the monthly premium payable for your spouse:	$1.10	
9	Enter the amount of Accidental Death coverage for yourself divided by 1,000	20	
10	Enter the amount of Accidental Death coverage for Spouse divided by 1,000	10	
11	Multiply amount in #9 by $0.04	$0.80	
12	Multiply amount in #10 by $0.04	$0.40	
13	Add #7, #8 ,#11 and #12	$4.90	
14	Annual Rate-Multiply the amount in #13 by 12 or by the number of remaining months in year for the current amount due. See example below. ***Annual Rates are billed every January**		
	Semi-Annual-Multiply the amount in #13 by 6 or by the number of remaining months in billing period for the amount due. See example below. ****Semi-Annual Rates are billed every January and July**		
	Quarterly-Multiply the amount in #13 by 3 or by the number of remaining months in billing period for the amount due. See example below. *****Quarterly Rates are billed every January, April, July and October**		
15	Enter the $2.00 Direct Billing Fee.	$2.00	
16	Add #14 and #15. This amount equals the total premium for you and your spouse's coverage for the frequency selected.		

Example 1 **Annual Rate -** Enrollment effective date of 4/1 your first premium will be for 9 months(4/1-12/31) for Annual billing period.

Example 2 **Semi Annual Rate -** Enrollment effective date of 4/1 your first premium will be for 3 months(4/1-6/31) for Semi-Annual billing period.

Example 3 **Quarterly Rate -** Enrollment effective date of 4/1 your first premium will be for 3 months(4/1-6/31) for Quarterly billing period.