SYMETRA®
RETIREMENT | BENEFITS | LIFE

Group Life Insurance Portability Kit

Life insurance protection after group coverage ends

Your group life insurance coverage—provided by Symetra Life Insurance Company—includes a provision called portability. This allows you to continue your coverage when you leave your job. And, you don't have to answer any medical questions.

Eligibility

You are eligible for portability coverage as long as:

- ✓ Your company's group life insurance policy, and the portability provision, is in-force at the time of application.
- ✓ You haven't reached Social Security Normal Retirement Age (SSNRA).
- ✓ You're not entering active military service.

How portability works

You can choose to continue 50%, 75% or 100% of your current life insurance benefit amount. Be sure to carefully consider all of your life insurance needs—if you decide to port a reduced percentage of your current life insurance benefit amount, you won't be able to continue any portion of the remaining amount at a later date.

Portability may also be available for your spouse and dependents. If this provision is included in your company's policy, you can select portability coverage as long as they are insured under the current group life policy at the time your group coverage terminates. Child coverage may only be ported if you or your spouse elects portability.[1]

Whatever you choose, the benefit amount will be rounded to the next higher multiple of $1,000 (example: $125,100 rounds to $126,000).

	Maximum Amount	Minimum Amount
You	$250,000	$5,000
Your spouse	$50,000	$5,000
Your dependent child	$10,000	$5,000

This chart represents standard benefit maximums. For more information on your company's policy, talk with your HR representative.

Frequently Asked Questions

Do I need a medical exam?
No. A medical exam is not required and you will not have to answer any medical questions.

How much does it cost?
The actual cost (rate) is based on your age at the time you are approved for portability and whether or not you have used tobacco products within the last 12 months. Rates are reviewed annually and may change.

Provision	Policy Type
Portability	**Group Term Life Insurance.** This type of policy provides protection until the age maximum is reached, provided that required premiums are paid. Pricing is determined by age, and tends to be lower than conversion. Coverage does not remain associated with the group life insurance policy that provided the right to port. There is no cash value.
Conversion	**Individual Permanent Life Insurance.** This type of policy provides lifetime protection provided that sufficient premiums are paid. Pricing is based on individual rates which tend to be more expensive than a ported policy. This is an individual policy so the employee is the policyowner rather than the group. The policy also accumulates a cash value that can be borrowed against, if needed.

My group life plan includes portability and conversion provisions. What's the difference?
The primary difference is the type of insurance policy you receive (see chart to the left).

Once I'm covered, will my benefit amount stay the same?
Your benefit amount remains the same when you port coverage. However, the benefit amount will reduce beginning at age 65. Contact your HR representative for more information.

Will I have life insurance coverage during the port period?
Yes. Your group insurance benefits remain in effect during the 31-day transition to the ported policy.

Can I convert to an individual policy if my coverage is reduced?
Yes, if your benefit amount is reduced due to the age reduction schedule, you can convert your ported coverage to individual coverage. The cost is based on your age at the time you apply for conversion so choosing to port first and convert at a later date may impact the amount of premium you pay.

Getting started

To apply for portability, fill out Part A of the enclosed application. Your employer is responsible for completing Part B.

Please don't delay. We need to receive your application and initial premium within 31 days from the date your group coverage ends.

Send your completed application and initial premium to:

Symetra Life Insurance Company
P.O. Box 1491
Minneapolis, MN 55480-1491

Getting Started

Don't miss the deadline. Complete your portability application today.

For more information on how to port your coverage, talk with your HR representative.

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

Group life insurance policies are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. Policy form number is LGC-13000 8/06 in most states and is not available in any U.S. territory. Our New York subsidiary insures products for New York policyholders. Policies contain exclusions, limitations, reduction of benefits and terms for keeping them in-force. Please contact your group life representative for complete details.

[1] Dependent children that have reached maximum issue age are not eligible to port their coverage.

Click here to clear form.

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 1491 | Minneapolis, MN 55480-1491
Phone 1-800-426-7784 | TTY/TDD 1-800-833-6388

APPLICATION FOR PORTABILITY CONTINUATION OF GROUP TERM LIFE INSURANCE

Part A: TO BE COMPLETED BY THE APPLICANT "Applicant" means the employee or member of the Group Policy from which coverage is being ported or the employee/member's eligible Spouse as defined in the Group Policy.

IMPORTANT INFORMATION—The enrollment period ends 31 days after the date the Group coverage ends. The application, enrollment form(s) and premium sent to Symetra must be postmarked within this 31 day period. *Submit your first premium with this application to Symetra Life Insurance Company at the above mailing address. Please make your check payable to Symetra Life Insurance Company.*

1. Applicant's Name _____ ☐ Employee/Member ☐ Spouse
2. Address _____

   _____

   Telephone No. Home (_____) _____ Cell (_____) _____

   Premium billing address for Life Insurance, if different than above:

   Address:_____
3. Birth Date _____ (mo-day-year) Sex: ☐ Male ☐ Female
4. Policyholder Name _____ Group Policy No. _____
5. **Important: The minimum and maximum amounts of insurance for which You are eligible are shown in your Group Insurance Certificate. Refer to the "Benefits" section, "Limitations" provision, for specific information.**

   ☐ Yes, I would like to continue my Portability Continuation Basic Life Insurance amount of $_____

   ☐ Yes, I would like to continue my Portability Continuation Supplemental Life Insurance amount of $ _____

   ☐ Yes, I would like to continue my Spouse Life Insurance amount of $ _____ Date of Birth _____ (mo-day-year)

   Spouse's Name *(If the Spouse is not the Applicant)* _____

   ☐ Yes, I would like to continue my Child Life Insurance amount of $ _____

   Child Name _____ Date of Birth _____ (mo-day-year)

   Child Name _____ Date of Birth _____ (mo-day-year)
   (Add additional pages if necessary)
6. Premium Mode: ☐ Quarterly $ _____ ☐ Semi-Annual $ _____ ☐ Annual $ _____
   In order to be eligible for Portability Continuation Insurance, you must submit your first premium with this application to Symetra Life Insurance Company at the mailing address above. Important: Premium modes other than annual are subject to a minimum premium payment of $50.
7. Please provide your last day of active work. _____ (mo-day-year)
8. Are you disabled? ☐ No ☐ Yes If yes, date of disability: from _____ (mo-day-year) to _____ (mo-day-year)
   If yes, have you applied for Waiver of Premium? ☐ No ☐ Yes
   Please note: If you have applied for Waiver of Premium, you may not be eligible for Portability.
   Diagnosis _____
9. Have you used any form of tobacco product within the last 12 months? ☐ No ☐ Yes Spouse? ☐ No ☐ Yes
   (Tobacco product includes cigarettes, cigars, pipes, chewing tobacco, snuff, etc.)

By signing below, I attest that the above information is correct to the best of my knowledge. I also attest that I have read and understand the fraud warning on the following page which applies to me.

Signature of Applicant _____ Date _____ (mo-day-year)

PLEASE HAVE THE GROUP POLICYHOLDER COMPLETE PART B THIS APPLICATION.

FRAUD WARNINGS All Other States: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI, WV: 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.

CA: For your protection California law requires the following to appear on this form: any person who knowingly presents 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.

CO: 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.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: 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.

FL: 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.

ID: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IN: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KY: 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.

ME: 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 denial of insurance benefits.

MD: 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.

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

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

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

NM: 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 civil fines and criminal penalties.

NY: 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 five thousand dollars and the stated value of the claim for each such violation.

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

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: 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.

TN, VA, WA: 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.

TX: 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.

Instructions:
Please fully complete this form and submit with ALL original enrollment cards and any requests for change of beneficiary.

Part B: TO BE COMPLETED BY THE GROUP POLICYHOLDER

"Applicant" means the employee or member of the Group Policy from which coverage is being ported or the employee/member's eligible Spouse as defined in the Group Policy.

1. Symetra Group Policy Number _____ Policyholder Name _____

   Division of _____

   Address _____

2. Applicant's Name _____ ☐ Employee/Member ☐ Spouse
3. Date of hire or membership of employee/member _____ (mo-day-year) Effective date of Applicant's life insurance _____ (mo-day-year)
4. Insurance class _____ Occupation _____
5. Current salary of employee/member (if applicable) $ _____ per ☐ hour ☐ week ☐ month ☐ year
6. Number of hours worked each week (if applicable) _____
7. Date employment or membership terminated _____ (mo-day-year) Last day of active work (if applicable) _____ (mo-day-year)
8. Date through which premiums were paid for this Applicant _____ (mo-day-year)
9. Is the Applicant disabled? ☐ No ☐ Yes If yes, date of disability: from _____ (mo-day-year) to _____ (mo-day-year)
10. Reason for stopping work (if applicable) _____
11. At time coverage terminated under this policy, the following amounts of Life Insurance were in force for each of the following:
    a. Applicant Basic $_____
    b. Applicant Supp $_____
    c. Applicant's Spouse $_____
    d. Applicant's Child(ren) $_____
12. Enrollment verification submitted? ☐ No ☐ Yes
    If no, please explain _____

Important: Applicants who choose to convert their Group Term Life Insurance coverage to an individual policy upon termination of employment are not eligible for Portability Continuation Insurance. Applicants who have applied for Waiver of Premium may not be eligible for Portability.

I hereby certify that: 1) the Applicant was a full-time, permanent, active employee or other eligible member with coverage under the Group Policy; 2) I am not a beneficiary, nor am I related to the beneficiary or the above individual; 3) I am an authorized policyholder representative; and 4) the above statements are true.

Name of person signing _____ Phone No. (___) _____

Email _____ FAX No. (_____) _____

By _____ (Signature) Title _____ Date _____ (mo-day-year)

How to Compute Portability Continuation Insurance Premium

Important: Premium modes other than annual are subject to a minimum premium payment of $50.

Employee Life Insurance

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67
Non Tobacco	$0.090	$0.100	$0.140	$0.210	$0.350	$0.530	$0.880	$1.400	$2.180
Tobacco	$0.170	$0.190	$0.230	$0.350	$0.570	$0.910	$1.430	$2.050	$3.620

To determine your cost for coverage, please determine your rate based on your age above, and then use the following formula(s) to calculate your cost:

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $_____ (Rate) = $_____ (Monthly Premium) x3 = $_____ (Quarterly Premium)

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $_____ (Rate) = $_____ (Monthly Premium) x6 = $_____ (Semi Annual Premium)

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $_____ (Rate) = $_____ (Monthly Premium) x12 = $_____ (Annual Premium)

Spouse Life Insurance

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67
Non Tobacco	$0.090	$0.100	$0.140	$0.210	$0.350	$0.530	$0.880	$1.400	$2.180
Tobacco	$0.170	$0.190	$0.230	$0.350	$0.570	$0.910	$1.430	$2.050	$3.620

To determine your cost for coverage, please determine your rate based on your age above, and then use the following formula(s) to calculate your cost:

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $_____ (Rate) = $_____ (Monthly Premium) x3 = $_____ (Quarterly Premium)

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $_____ (Rate) = $_____ (Monthly Premium) x6 = $_____ (Semi Annual Premium)

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $_____ (Rate) = $_____ (Monthly Premium) x12 = $_____ (Annual Premium)

Dependent Child Life Insurance

Rate	$0.220

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $ 0.220 (Rate) = $_____ (Monthly Premium) x3 = $_____ (Quarterly Premium)

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $ 0.220 (Rate) = $_____ (Monthly Premium) x6 = $_____ (Semi Annual Premium)

$_____ (Life Benefit Amount) ÷ 1,000 = $_____ x $ 0.220 (Rate) = $_____ (Monthly Premium) x12 = $_____ (Annual Premium)

Total Portability Premium

$_____ Quarterly Total

$_____ Semi Annual Total

$_____ Annual Total

Beneficiary Information

Primary Insured _____ Effective Date_____

Symetra Life Insurance Company and the Insured agree as follows:
Symetra Life Insurance Company will make payment to the most recently named beneficiary as shown below.

Primary *(Print each name in full)*

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Contingent *(Print each name in full)*

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Primary Insured's signature _____ Date _____