



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" section of the application.
- Be sure that:
 - All items are completed.
 - The form is signed by your authorized representative.
- Return the application to your employee instructing them to complete the "Request for Portability of Group Term Life Insurance" section of the application.

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" section of the application in its entirety.
 - Consult the Rate Tables and instructions (included in the kit) to determine insurance amounts and costs.
 - Consult the Portability Plan Outline for the:
 - Guaranteed Standard Issue amount (GSI); and
 - Portability Maximum

If the two amounts are the same, evidence of good health will **not** be required for the coverage that you are requesting. If the Portability Maximum is more than the GSI and you are requesting more than the GSI, evidence of good health **will** be required for amounts above the GSI. If Aetna sees on your application that you are applying for more than the GSI, Aetna will send you an Evidence of Insurability form which you must complete and return to Aetna within 31-days of the date the form is sent to you.

If after Aetna reviews the medical information you are approved for the coverage that you have requested, Aetna will send you a bill for the additional coverage, so the check that you are sending to Aetna with the application should **not** be for more than the GSI. Once you receive the bill you will have 31 days to pay for the amount that is above the GSI. If your payment is not received within 31 days, your coverage amount will be limited to the GSI.

If Aetna is not able to approve your request for the amount that is above the GSI, your coverage will be limited to the GSI, however, you will have the option to convert the coverage that Aetna was not able to approve to an individual whole life policy, provided your application for conversion coverage is returned to Aetna within 31 days of the date on the conversion letter.
 - Be sure that:
 - All items are completed.
 - The form is signed by you.
 - Make a copy of the application for your records and mail the original to:
 - Aetna Life Insurance Company
 - Group Insurance
 - 151 Farmington Avenue
 - Hartford, CT 06156-7350
- If you have any questions, call us toll-free at:
1-800-826-7448

Please call Aetna's toll-free number if you have any questions about how to complete the Request for Portability of Group Term Life Insurance form.



Request for Portability of Group Term Life Insurance

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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. The first premium payment should not be for more than the Guaranteed Standard Issue amount, if you are eligible for and are applying for more than that amount.

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

Former Employer's Name Maine Public Employees Retirement System

Employee Coverage (Please Print – Shaded areas are required fields and MUST be completed)

1. Employee Name (First, Middle Initial, Last)		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Birthdate (MM/DD/YYYY)
4. Residence (Number, Street, City, County, State, Zip Code)		5. Social Security Number □ □ □ - □ □ - □ □ □ □	
4a. Email Address _____		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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Accidental Death Amount \$ _____ <input type="checkbox"/> Life Disability Benefit (Waiver of Premium)	
9a. Guaranteed Standard Issue Amount at Termination: \$ _____			
9b. Portability Maximum at Termination: \$ _____			
11. Have you (employee) used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Spouse Coverage (Please Print)

1. Spouse Name (First, Middle Initial, Last)		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> 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. Has spouse used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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
a. Primary _____	□ □ □ - □ □ - □ □ □ □	_____	_____
b. 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 <input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> 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's rights 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 Arkansas, 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 California Residents: For your protection California law requires 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 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky 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 may subject such person to criminal and civil penalties.

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 denial of insurance benefits.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information 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.

Attention North Carolina Residents: 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 may be a crime and subjects such person to criminal and civil penalties.

Attention 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 Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington 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.

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 tobacco user and non-tobacco user. Select the appropriate tobacco user or non-tobacco user 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-tobacco user.

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 - Employee and Spouse

Issue Age	Employee Non-Tobacco user	Employee Tobacco user	Spouse Non-Tobacco user	Spouse Tobacco user
15-19	0.0720	0.1230	0.0720	0.1230
20-24	0.0720	0.1230	0.0720	0.1230
25-29	0.0720	0.1230	0.0720	0.1230
30-34	0.0820	0.1400	0.0820	0.1400
35-39	0.1130	0.1950	0.1130	0.1950
40-44	0.1650	0.2850	0.1650	0.2850
45-49	0.2900	0.5000	0.2900	0.5000
50-54	0.4640	0.8050	0.4640	0.8050
55-59	0.7310	1.2750	0.7310	1.2750
60-64	1.1540	2.0250	1.1540	2.0250
65-69	1.9980	3.5130	1.9980	3.5130
70-74	3.5120	6.1630	3.5120	6.1630
75-79	6.1490	10.7880	6.1490	10.7880
80-84	10.7640	18.8750	10.7640	18.8750
85-89	18.8390	33.0380	18.8390	33.0380
90-94	32.9700	57.8130	32.9700	57.8130
95-99	57.7010	101.1750	57.7010	101.1750

Monthly Rates - Accidental Death Coverage

\$0.04 per thousand dollars of coverage

Monthly Rates - Dependent Child(ren)

\$0.20 per thousand dollars of coverage



Turning promise into practice

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.

<u>Employee Spouse Coverage</u>		<u>Example</u>	<u>Your Cost Estimate</u>
1	Enter the amount of insurance requested on yourself, but do not enter more than Guaranteed Standard Issue amount even if you are requesting more than the amount on your application.	\$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, but do not enter more than Guaranteed Standard Issue amount even if you are requesting more than the amount on your application.	\$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 tobacco user status.	\$0.1330	_____
6	From Table 1, enter the Monthly premium rate which corresponds with your spouse's age and tobacco user status:	\$0.1130	_____
7	Multiply #5 by #2 . This is the monthly premium payable for you:	\$2.66	_____
8	Multiply #6 by #4. This is the monthly premium payable for your spouse	\$1.13	_____
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	\$4.99	_____
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.	_____	_____

Note: If you are requesting more than the Guaranteed Standard Issue amount, you will be billed separately for that amount if evidence of good health is approved. Do not send premium for that amount with your first payment.

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(4/1-6/30) for Semi-Annual billing period.

Example 3 Quarterly Rate - Enrollment effective date of 4/1 your first premium will be for 3 months(4/1-6/30) for Quarterly billing period.