



Underwritten by  
United of Omaha Life Insurance Company  
A Mutual of Omaha Company

**Group Portability**  
3300 Mutual of Omaha Plaza  
Omaha, NE 68175-0001  
(954) 845-6066 Option 2

## A Guide for Successfully Completing the Mutual of Omaha Term Life Portability Request Form

Mutual of Omaha appreciates the opportunity to provide you with valuable life insurance protection for yourself and/or your loved ones. So that we can effectively process your request for life insurance under the Term Life Portability Plan, we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

### About the Form

The Term Life Enhanced Portability Form is a request for insurance under Mutual of Omaha's Term Life Portability Plan. Insurance under this plan is available to employees/members (hereafter referred to as "members") and/or eligible dependents when insurance under a Mutual of Omaha group term life insurance plan (voluntary and/or basic) offered by an employer/group ceases.

A completed and signed form with initial premium payment **MUST** be received by Mutual of Omaha within 60 days after insurance has ceased under the group plan for your request to be considered. All sections of the form are to be completed. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of the form will be delayed. Please contact the employer/benefits administrator to determine or confirm information as needed.

Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.

#### Section 1: Employer/Group Information

Provide the name and ID number for the employer/group. The number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to the employer/group. The original date of hire or date of association for the member must also be provided.

#### Section 2: Applicant Information

Please provide all required applicant information. If the Member is eligible to port insurance, the member must be the applicant and elect insurance for dependents to be eligible. If the member is not eligible to port insurance, the spouse (in the event of divorce or the employee's death, for example) can be the applicant and is eligible to port term life insurance for her/himself and dependents.

To ensure any additional correspondence regarding your request occurs as quickly as possible, check the box to consent to receive future correspondence via email.

## Section 3: Portability Insurance Election & Initial Premium Payment Calculation

To complete insurance election and initial premium payment calculation, the type of insurance requested must be indicated, then premium amounts must be calculated for each individual for whom ported insurance is being requested, and a billing mode must be selected.

First, select the type of insurance requested, either "Life Insurance Only" or "Life and AD&D Insurance." If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose.

Next, do the following to complete this section:

(1) Provide the first name of each individual for whom ported insurance is being requested.

(2) Provide the Insurance Amount each individual is requesting (rounded up to the nearest \$1,000), subject to the following:

- The Insurance Amount for each individual must be less than or equal to the amount of insurance the individual had when insurance ceased under the group plan, not to exceed \$500,000. The maximum amounts are equivalent to the Current Insurance Amounts indicated in Section 4.
- The Insurance Amount for the employee must be \$10,000 or more. The Insurance Amount for spouse must be \$5,000 or more, and for child(ren), \$2,000 or more.
- If the applicant is an employee, dependent spouse and child(ren) insurance amounts must be less than or equal to 50% of the insurance amount applied for by the member.
- Insurance Amount(s) must be in increments of \$5,000 for the member and/or spouse. (Example: \$10,000 and \$25,000 are acceptable insurance amounts, but \$12,000 and \$27,000 are not.) The Insurance Amount for child(ren) must be in \$1,000 increments.

(3) Calculate the Coverage Factor for each individual, by dividing your Insurance Amount (2) by 1,000. (Example:  $\$25,000 / 1,000 = 25$ ; 25 is the Coverage Factor.)

❖ Insert the appropriate monthly rate per \$1,000 of insurance for each individual, for the current age for member and/or spouse. Rates are provided in Section 5. If you are requesting both life and AD&D insurance, you must add the AD&D monthly rate per \$1,000 (\$0.060) to the life monthly rate per \$1,000 to obtain the appropriate monthly rate per \$1,000. (Example: The appropriate monthly rate per \$1,000 for a 34 year old applicant requesting life and AD&D coverage is \$0.254 (\$0.194 for Life plus \$0.060 for AD&D).)

❖ Calculate the Monthly Premium for each individual, by multiplying the Coverage Factor (3) by the Monthly Rate (4).

❖ Calculate the Total Monthly Premium, by adding together all of the amounts in the Monthly Premium (5) column.

❖ Select a billing frequency. To pay premium every 3 months (quarterly), insert a "3" into column (7). To pay premium twice a year (semi-annually), insert a "6" into column (7). To pay premium annually, insert a "12" into column (7).

❖ Calculate the Initial Premium Payment, by multiplying the Total Monthly Premium (6) by the Billing Frequency (7).

## Section 4: Beneficiary For Death Benefits

You must designate a beneficiary for any life insurance proceeds in the event of your death. You (the applicant) are the beneficiary for any dependent life insurance.

If you wish to designate additional beneficiaries (beyond what space allows for on the form), please attach an additional sheet of paper to the form that includes the required information.

## Section 5: Acknowledgement and Signature

Read the statements in this section. If you understand and agree to the statements, sign and date the form to complete the form. Your signature binds you to the statements in this section, and allows the form to be processed by Mutual of Omaha.

## Section 6: Instructions

Follow these instructions to ensure your request is properly submitted and received by Mutual of Omaha. Be sure to include the Group ID Number on any payment, and mail the request form and the payment to Mutual of Omaha as soon as possible after your coverage ends under the group plan.

Remember, to be considered for coverage under the Term Life Portability Plan, your request must be received within 60 days of the date coverage under the group plan ended.



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## Term Life Portability Request Form

Please refer to "A Guide for Successfully Completing the Term Life Portability Request Form" when completing this form. Please consult the employer/benefits administrator if you need assistance with information for the form.

### Section 1: Group Information and Date of Hire/Association (Please print clearly. Required fields are marked with an asterisk (\*).)

Group/Employer Name*	Group ID Number*	Date of Hire/Association (MM/DD/YYYY)*
	G000 ____	

### Section 2: Applicant Information (Please print clearly. Required fields are marked with an asterisk (\*).)

Last Name*	First Name*	MI
Street Address*		Email Address

City*	State*	ZIP Code*	Telephone*
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Birth Date (MM/DD/YYYY)*†	Social Security Number*	Gender*
		<input type="checkbox"/> Female <input type="checkbox"/> Male

†The applicant must be the Attained Age of 70 or less to be eligible for insurance.

#### Consent to Email Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this request via email.

**Applicant Type\*** **Individuals for Whom Ported Insurance is Being Requested\*** (†Applies to employee/member applicants)

<input type="checkbox"/> Employee/Member	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself & Spouse†	<input type="checkbox"/> Myself, Spouse & Child(ren)†	<input type="checkbox"/> Myself & Child(ren)
<input type="checkbox"/> Spouse				

#### Reason for Request\*

If you are an employee/member applicant, indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:

<input type="checkbox"/> Status Change/Reduction in Hours	<input type="checkbox"/> Employment/Association Terminated	<input type="checkbox"/> Plan Terminated by Group/Employer	<input type="checkbox"/> Employee/Member Retirement
Date of Change: _____	Date of Termination: _____	Date of Termination: _____	Date of Retirement: _____

If you are a spouse applicant, please indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:

<input type="checkbox"/> Divorce	<input type="checkbox"/> Death of Employee/Member	<input type="checkbox"/> Ineligible Due to Employee/Member Age	<input type="checkbox"/> Ineligible Due to Employee/Member Active
Date of Divorce: _____	Date of Death: _____	Date of Ineligibility: _____	Military Status; Date of Ineligibility: _____

**Section 3: Portability Insurance Election & Initial Premium Payment Calculation**

Type of Insurance Requested ☐ Basic Life and AD&D Insurance Only ☐ Voluntary Life and AD&D Insurance Only  
☐ Both

**Initial Premium Payment Calculation**

	(1) First Name	(2) Insurance Amount	(3) Coverage Factor (2) / 1,000	(4) Monthly Rate Life + AD&D if applicable	(5) Monthly Premium (3) X (4)	(6) Total Monthly Premium Sum of column (5) amounts	(7) Billing Frequency	(8) Initial Premium Payment (6) X (7)
Basic Life and AD&D						\$ _____	_____	\$ _____
Voluntary Life and AD&D - 1.25x Annual Salary*								
Voluntary Life and AD&D - 2.5x - 5.0x Annual Salary*								
	*Complete row for benefit amount that you have elected.							

**Section 4: Beneficiary For Death Benefits**

**Important Note:** AZ, CA, ID, LA, NV, NM, TX, WA and WI are community property states. If you live in a community property state and you designate someone other than your spouse as a beneficiary, state law requires that your spouse consent to such designation. If you do not obtain your spouse's consent to the foregoing designation(s), then such designation(s) may not be effective.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

**Primary Beneficiary Designation**

Last Name	First Name	Relationship to Applicant	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
Percentage Total:					100%

**Secondary Beneficiary Designation**

Last Name	First Name	Relationship to Applicant	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
Percentage Total:					100%

**Section 5: Acknowledgement and Signature**

I understand that I may request insurance under the portability plan subject to the following:

- I understand that this insurance is subject to the rules of the policy governing the portability plan.
- I understand that the individuals covered under this plan must satisfy the plan's requirements to be eligible for benefits and that payment of premium does not ensure eligibility for insurance. In the event that any premium is collected after eligibility for portability insurance ceases, I understand that the unearned premium will be refunded in accordance with the terms of the policy governing the portability plan.
- This request for insurance must be received by Mutual of Omaha within 60 days of the date that insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha.
- Premium amounts may increase if any of the individuals insured under the plan enter a higher premium age category, or if portability plan experience requires a change for all individuals insured under the plan.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section 6: Instructions**

- 1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ceased under the group plan. The form and payment must be received by Mutual of Omaha within 60 days of the date insurance under the group plan ended.
- 2) Make the check or money order for the Initial Premium Payment payable to United of Omaha Life Insurance Company. Be sure to include the Group ID Number (from Section 1) on the payment.
- 3) Submit this form and payment to:  
Mutual of Omaha  
Policyowner Services  
P.O. Box 2147  
Omaha, NE 68103-2147

If you have any questions regarding this form, please contact the employer/benefits administrator, or contact Mutual of Omaha at (954) 845-6066 Option 2.