Group Term Life Insurance Portability Election Form

KMG AMERICA
KANAWHA INSURANCE COMPANY

If your Group Life Master Policy and Certificate contain a Portability provision, you may elect the Portability coverage, subject to the limitations and conditions as described within the provision. You must apply for Portability coverage within 31 days after termination of your life insurance benefits. For those who are eligible, complete this form and return it to Kanawha Insurance Company, Group Administration, Post Office Box 610, Lancaster, South Carolina 29721-0610.

However, if you are Totally Disabled, you are not eligible for the Portability provision.

If you have any questions, you may contact Group Administration at **1-800-584-4214**.

Section I. Employee Information to be Completed by the Employer

Name ______________________ Date of Birth ______________________

Address ______________________

City ______________ State ______________ ZIP ______________

Social Security Number ______________________ Home Telephone ______________________

Group Life Master Policy Number ______________________ Date of Coverage Termination ______________________

Date of Employment Termination ______________________ Last Day Worked ______________________

Annual Salary at Termination $ ______________________

Reason for Termination ______________________

I certify that, to the best of my knowledge and belief, the information provided in this Section is correct and the Employee named on this Form is eligible for Portability coverage. **I have provided the Insured/Employee with a copy of their enrollment form as well as any benefit and/or beneficiary changes.**

______________________ ______________________

Signature of Authorized Company Representative Date

______________________ ______________________

Title of Authorized Company Representative Name of Company

Section II. To be Completed by the Insured/Employee

I, the Employee indicated in Section I., understand and agree that Portability coverage will be provided in accordance with the provisions contained in the Group Term Life Insurance Master Policy, and that such coverage is subject to the satisfaction of the conditions therein. I understand and agree that I am not eligible for continued coverage if the reason for my termination of employment was due to total disability.

Mark an "X" by the Billing Frequency of your choice.

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

A service charge of $5.00 will be included on each billing statement.

Please sign, date, and submit this form along with a copy of your enrollment form and any documentation of changes provided by your employer to Kanawha Insurance Company, Group Administration, P. O. Box 610, Lancaster, South Carolina 29721-0610.

______________________ ______________________

Signature of Insured/Employee Date

Kanawha Insurance Company is a wholly-owned subsidiary of KMG America.

210 South White Street, Lancaster, SC 29720 **Mail: Post Office Box 610, Lancaster, SC 29721-0610**