Group Term Life Insurance Portability Election Form
Kanawha Insurance Company

Humana®

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 46 days after termination of your life insurance benefits. For those who are eligible, complete this form and return it to Humana Specialty Benefits Enrollments, PO Box 14330, Lexington, Kentucky 40512.

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

If you have any questions, you may contact Humana Specialty Benefits Enrollments at **800-232-2006** or Fax **1-866-584-9140**.

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 K10066405 Date of Coverage Termination _____

Date of Employment Termination _____ Last Day Worked _____

Annual Salary at Termination $ _____

Reason for Termination Termination of Employment

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

Authorized DCBOE Representativ — Decatur County Board of Educatio

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.

Billing frequency will be monthly.

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 Humana Specialty Benefits Enrollments, PO Box 14330, Lexington, Kentucky 40512.

_____ _____

Signature of Insured/Employee — Date

Decatur County Board of Education - Bainbridge, Geor

Humana Specialty Benefits Enrollments, 2342 Fortune Drive, Suite 120, Lexington, Kentucky 40509
Mail: Humana Specialty Benefits Enrollments, PO Box 14330, Lexington, Kentucky 40512

K100