

Gerber Life Insurance Company

Election of Portability Coverage

State of North Carolina
 NCFlex Voluntary AD&D
 Policy# PAI - 119446

Please complete and return to:
A C Newman & Company.
 7060 N. Marks Ave., Suite 108
 Fresno, CA 93711
 (559) 252-2525

If your group coverage ends due to employment termination or retirement, you may be eligible for portable coverage. If you had dependent coverage under your group plan, you may be eligible to elect portable coverage for your dependents.

To apply, you must complete this form and send it to AC Newman & Company within 45 days after your group insurance coverage ends. Portable coverage will be effective the later of: 1) the date your coverage ends under the group plan; 2) the date of your application for portable coverage; or 3) the date your premium for portable coverage is paid.

TO BE COMPLETED BY EMPLOYEE (Signature required below)

AD&D Amount at Termination Date \$	Termination Date	Reason
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TO BE COMPLETED BY EMPLOYEE (Signature required below)

Name of Agency / University / Community College	Address of Agency / University / Community College
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Insured Name (last, first, m.i.)	Home Telephone Number
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Insured Mailing Address (Street, PO Box, City, State, Zip)

Social Security Number	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Current Plan Selection (check one): **Insured Only** **Insured & Family**

Amount of Coverage \$ _____ (not to exceed amount stated above; subject to minimum of \$50,000.00).

Premium Calculation: Please complete the information below.

RATES: **Insured Only = .019** per 1,000 of coverage **Insured & Family = .03** per 1,000 of coverage

Actual	Instructions	Example: Insured & Family
1) \$ _____	1) Amount of Coverage	1) \$ _____ 50,000
2) \$ _____ ÷ 1,000 = <input type="text"/>	2) Amount of Coverage divided by 1,000	2) \$ _____ 50,000 ÷ 1,000 = <input type="text" value="50"/>
3) _____ x _____	3) Multiply amount in 2) by applicable rate above	3) _____ 50 x .03
4) \$ _____	4) Monthly Cost	4) \$ _____ 1.50
5) \$ _____ x 12	5) Multiply Monthly Cost By 12 for Annual Cost	5) \$ _____ 1.50 x 12
6) \$ _____	6) Annual Cost	6) \$ _____ \$18.00

Please note all premiums are paid annually. Please mail your initial premium payment, along with this application, to the address shown above. Make your check payable to: **A C Newman & Company**

Spouse Name: _____

Spouse Date of Birth: _____ **Spouse Social Security No.:** _____

Name of Primary Beneficiary: _____ **Relationship to you:** _____

Name of Contingent Beneficiary: _____ **Relationship to you:** _____

Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the employer's AC Newman & Company Voluntary AD&D insurance coverage under which this coverage is offered and is subject to satisfaction of the conditions provided therein.

If no dependent coverage is available under your group plan then any reference to dependent coverage is not applicable.

If you have any questions concerning your eligibility for portability coverage, please contact a representative at 1 (800) 257-0930.

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage for which I am applying.

Insured Signature _____ Date _____ Signature of Authorized Employer Representative _____ Date _____