LifeMap Assurance Company™
100 SW Market Street
P.O. Box 1271, MS E-3A
Portland, OR 97207-1271
(503) 721-7161 (800) 794-5390

HOME OFFICE USE ONLY	
OED:	Policy #:

REQUEST FOR PORTABILITY OF LIFE INSURANCE

To Be Completed By Applicant

EMPLOYEE NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH
SPOUSE NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH

MAILING ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.

EMPLOYEE (Please check the appropriate boxes and complete the following):

Eligible reasons for Porting: ☐ Termination of employment ☐ Employee ceased to be in an eligible class

Ineligible reasons for Porting (Policy cannot be issued): ☐ Retired ☐ Your disability ☐ Extended military leave or absence

☐ Continue the same amount of Basic Life coverage I had through the employer - **OR**
☐ Decrease to a lesser amount (enter in $1,000 increments) $ _____

☐ Continue the same amount of Voluntary Life coverage I had through the employer - **OR**
☐ Decrease to a lesser amount (enter in $1,000 increments) $ _____

SPOUSE (Please check the appropriate boxes and complete the following):

☐ Continue the Basic Life coverage

☐ Continue the same amount of Voluntary Life coverage the spouse had under the employer – **OR**
☐ Decrease to a lesser amount (enter in $1,000 increments) $ _____

(Spouse may port coverage without the Employee only if election is due to one of the reasons listed below)

Reason for Porting: (check one) Coverage terminated due to:

☐ Death of Employee ☐ Divorce from Employee ☐ Legal separation from Employee ☐ Termination of Domestic Partnership

DEPENDENT CHILD(REN) UNDER AGE 26 COVERAGE: (Please check the appropriate boxes and complete the Dependent Child Coverage Sheet):

☐ Continue the Basic Life coverage

(May be elected by Spouse only if Employee is not electing Portability coverage due to death, divorce or separation)

FREQUENCY OF PAYMENTS: ☐ Annually ☐ Semi-Annually ☐ Quarterly

FIRST PREMIUM PAYMENT MUST BE SENT WITH THIS COMPLETED FORM (*See "Premium Calculation Sheet" on Page 4*)

➔APPLICANT SIGNATURE (Form is not valid until signed and dated)	➔DATE

To Be Completed By Employer

DATE EMPLOYEE TERMINATED EMPLOYMENT OR BECAME INELIGIBLE FOR INSURANCE	DATE EMPLOYEE COVERAGE TERMINATED	DATE SPOUSE COVERAGE TERMINATED
EMPLOYEE LIFE INSURANCE AMOUNT Basic: $_____ Voluntary: $_____	BASIC DEPENDENT LIFE INSURANCE ☐ Yes ☐ No	DEPENDENT VOLUNTARY LIFE INSURANCE Spouse: $_____ Child(ren) $_____
POLICYHOLDER NAME: **LEWIS & CLARK COLLEGE**		GROUP POLICY NO. **WBT 000528**
➔SIGNATURE OF POLICYHOLDER REPRESENTATIVE		**➔DATE**

DEPENDENT CHILD(REN) COVERAGE SHEET

(To be completed if electing coverage for Dependent Child(ren) under the age of 26)

CHILD(REN) NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH
CHILD(REN) NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH
CHILD(REN) NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH
CHILD(REN) NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH
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CHILD(REN) NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH
CHILD(REN) NAME IN FULL	SOCIAL SECURITY NO.	DATE OF BIRTH

Termination of Portability coverage for Dependent Child is the date the child ceases to qualify under the terms "Child(ren)" or "Dependent" as defined as the Group Policy.

LIFEMAP ASSURANCE COMPANY
BENEFICIARY DESIGNATION FORM

INSURED LAST NAME	FIRST (Given Name)	INITIAL	GROUP POLICY NO.

PRIMARY BENEFICIARY (If naming more than two beneficiaries, please use the other side of this form.)

BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Da	Yr	SEX M	F	SOCIAL SECURITY NO.	
BENEFICIARY ADDRESS	CITY	STATE				ZIP		RELATIONSHIP TO YOU	BENEFIT %

PRIMARY BENEFICIARY

BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Da	Yr	SEX M	F	SOCIAL SECURITY NO.	
BENEFICIARY ADDRESS	CITY	STATE				ZIP		RELATIONSHIP TO YOU	BENEFIT %

CONTINGENT BENEFICIARY (Receives proceeds only if the Primary Beneficiary(ies) dies before you.)

BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Da	Yr	SEX M	F	SOCIAL SECURITY NO.
BENEFICIARY ADDRESS	CITY	STATE				ZIP		RELATIONSHIP TO YOU

THIS DESIGNATION IS NOT VALID UNLESS SIGNED AND DATED BY INSURED.
(Form must be completed by Employee, unless qualified Spouse only coverage is elected)

SIGNATURE _____ **DATE** _____

Please provide full name, date of birth, Social Security number and address of your beneficiary. Examples follow:

A.	One Beneficiary	Mary R. Jones, 1234 Hemlock St., Anytown, USA 12345
B.	Two Beneficiaries	John Jones and Sally Smith, equally, or the survivor (list information for both)
C.	Two Beneficiaries in Unequal Shares	John Jones, 75% and Sally Smith, 25%, or the survivor (list information for both)
D.	One Primary and One Contingent Beneficiary	Mary R. Jones, if living, otherwise Sally Smith (list information for both)
E.	One Primary and Two Contingent Beneficiaries	Mary R. Jones, if living, otherwise Sally Smith and John Jones, equally, or the survivor (list information for all)
F.	Trustee	Mary R. Jones, Trustee, under trust agreement dated
G.	Insured's Estate	My Estate

Do you know that if death occurs and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a Guardian of the Estate of the minor or a Conservator for the minor appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.

Submit completed beneficiary form along with completed Portability form to:

LifeMap Assurance Company
PO Box 1271, MS E3A
Portland Oregon 97207-1271

PORTABILITY COVERAGE PREMIUM CALCULATION SHEET
NOTE: If you are not porting Spouse coverage, please leave those areas blank.

Step 1 – Determine Monthly Basic Rate

Employee Rate is $0.137 per $1,000 of Coverage **$**_____
(Multiply rate by Basic coverage amount to be ported. Example: $0.137X 20 ($20,000) = $2.74)

Dependent Rate (Spouse and/or Child) is $2.54 Per Family per Month **$**_____
(Enter $2.54 if choosing Dependent and/or Spouse only coverage)

Step 1a – Determine Monthly Voluntary Rate

Find the correct rate below, based on the Employee's and/or Spouse's current age and gender. Rates are based on $1,000 of coverage.

(Multiply rate by Voluntary coverage amount to be ported. Example: $0.36 X 50 ($50,000) = $18.00)

Employee rate $_____ X (coverage amount) $ _____ = **$**_____

Spouse rate $_____ X (coverage amount) $ _____ = **$**_____

Step 2 – Monthly Sub-Total: Add together monthly totals from Step 1 and Step 1a **$**_____

Step 3 - Mode of Payment - **Choose One**:

For Annual payment, multiply the sub-total amount in Step 2 by 12.
For Semi-Annual payment, multiply the sub-total amount in Step 2 by 6.
For Quarterly payment, multiply the sub-total amount in Step 2 by 3. **Premium Sub-Total $**_____

Step 4 - Administrative Fee: Add to the amount determined in Step 3. **+ $ 5.00**_____

Your Premium Payment For Portability Coverage **Grand Total $**_____

Check or money order for the first premium payment must be sent with this completed form to the following address:

LifeMap Assurance Company
P O Box 1271, MS E3A
Portland, Oregon 97207-1271

Premium must be received **within 31 days** of the date coverage terminates under the group policy. We will bill you for future payments, 2-4 weeks before your next premium due date.

VOLUNTARY RATES FOR PORTABILITY COVERAGE

EMPLOYEE AND SPOUSE MONTHLY RATE PER $1,000 OF COVERAGE

MALE RATES		FEMALE RATES	
Age	**Rate**	**Age**	**Rate**
Under 25	$ 0.06	Under 25	$ 0.04
25 – 29	0.06	25 – 29	0.04
30 – 34	0.08	30 – 34	0.05
35 – 39	0.09	35 – 39	0.06
40 – 44	0.17	40 – 44	0.08
45 – 49	0.30	45 – 49	0.14
50 – 54	0.51	50 – 54	0.23
55 – 59	0.92	55 – 59	0.36
60 – 64	1.05	60 - 64	0.47
65 – 69	1.86	65 – 69	0.84

All Portability insurance benefits terminate on the premium due date next following the Insured Person's 70th birthday.