Request for Portability of Supplemental Employee & Dependent Life Insurance

This form must be received by UnitedHealthcare within 31 days of Date of Termination of Coverage.
PLEASE NOTE: ALL SECTIONS OF THIS FORM MUST BE COMPLETE FOR US TO PROCESS YOUR REQUEST.

Sections A, B and C to be completed by Employer

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G. Premium Calculation (see attached calculation sheet for details)

Please indicate Quarterly or Annual Billing:

☐ Quarterly ☐ Annual

Have you or your dependents used tobacco of any kind during the last twelve months? ☐ Yes ☐ No

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Portability Premium Rates

Current Rates for Term Insurance

	Non-Tobacco Rates per $1,000 of Insurance	Tobacco