Request for Portability of Long Term Disability

UnitedHealthcare

This form must be received by UnitedHealthcare Specialty Benefits 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 and B to be completed by Employer

A. Employer Information about EMPLOYEE

Employee Last Name	First Name	M.I.	Date of Birth	Date of Hire

Employee's Long Term Disability Coverage Amount	Social Security Number
Annual Salary at Termination	Date of Coverage Termination

Did the Employee's coverage terminate as a result of not being actively at work due to disability? ☐ Yes ☐ No

Did the Employee's coverage terminate because he did not return to work after recovering from a disability? ☐ Yes ☐ No

Did the Employee's coverage terminate because he was not actively at work due to an approved leave of absence? ☐ Yes ☐ No

Did the Employee's coverage terminate due to retirement? ☐ Yes ☐ No

The Employee will not be eligible to Port the Long Term Disability Coverage if any of the above "yes" boxes are marked.

Was the Employee insured under this LTD policy for at least 12 months? ☐ Yes ☐ No

The Employee will not be eligible to Port the Long Term Disability Coverage if not insured under this LTD policy for at least 12 months.

B. Employer Information

Employer's Signature	Printed Name	
Company Phone Number	Date	
Employer Name	Group Policy Number	Date Given to Employee

Sections C, D and E to be completed by Employee

C. Employee Information

Address (Street, City, State and ZIP Code) Phone Number

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

Please indicate Quarterly or Annual Billing:

☐ Quarterly ☐ Annual

Employee's premium amount: $_____

Total payment required with this form: $_____

E. Employee Signature

I have been notified of my option for ported coverage. I understand that I must exercise my right to port within 31 days of the date my coverage ends. **Enclosed with this form is my first quarterly OR first annual premium.** I hereby authorize the insurer to begin billing me directly for my Long Term Disability Insurance Plan.

Insured Employee Date

Make your check payable to UnitedHealthcare Specialty Benefits.
Mail this completed form with your premium to:

UnitedHealthcare Specialty Benefits
9700 Health Care Lane – 8th Floor
MN017-E800
Minnetonka, MN 55343

Please retain your Group Certificate from your former Employer. A separate Portability certificate will not be issued.

Please direct Portability inquiries to 1-877-683-8601

UnitedHealthcare Specialty Benefits insurance products are underwritten by UnitedHealthcare Insurance Company (rated A+ by Standard & Poors), Unimerica Insurance Company (rated A by A.M. Best), Unimerica Life Insurance Company (rated A by A.M. Best) or Unimerica Life Insurance Company of New York (rated A by A.M. Best). Some products may not be available in certain states.

UnitedHealthcare Specialty Benefits Use Only

Date Received	Group Number

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How to Calculate your Premium:	***Example:***
Determine whether you wish to pay your premium quarterly or annually.	*A disabled employee decides to continue their long term disability coverage and pay premiums quarterly.*
Find your monthly rate. If the rate is age-based, the rate is based on your age at the time your coverage begins, which is 31 days from the time your group coverage terminates or is reduced. As your age increases, your rate will increase as well.	*The monthly rate for a 50 year old is $0.34 for each $100 of insurance.*
Determine your monthly earnings.	*The person's monthly earnings are $4,000*
Premium Calculation:	
a. Rate per one hundred dollars of coverage: $_____	*a. $0.34*
b. Monthly earnings divided by 100: $_____	*b. 40 ($4,000 monthly earnings divided by $100)*
c. Multiply a times b. This is your monthly premium: $_____	*c. $13.60 ($0.34 multiplied by 40)*
d. Multiply c times 3. This is your quarterly premium: $_____	*d. $40.80 ($13.60 multiplied by 3)*