reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

Critical Illness Insurance Portability Request

This form is to be used only when a person desires and is eligible to port Critical Illness Insurance. This form must be completed in full and submitted to The Company within 31 days following the date of termination of insurance coverage.
SEND TO: Amwins Group Benefits, Inc., P.O. Box 152501, Irving, TX 75015-2501 - irvcustomerservice@amwins.com
Fax number: 469-417-1675.

VERIFICATION OF INSURED PERSON'S ELIGIBILITY TO PORT CRITICAL ILLNESS INSURANCE

To Be Completed By Policyholder/Participating Unit

☐ Male ☐ Female

1. Insured Person's full name_____ 2. Soc. Sec. Number_____
(Please Print)

3. Name of Policyholder/Participating Unit _____4. Policyholder/Participating Unit No.: _VCI _____

5. Branch or Location (if different from 3.) _____

6. Date of Hire:_____ Class: _____

7. Effective Date of Coverage: Employee:_____ Spouse, if any:_____ Child(ren), if any:_____

8. Occupation/Job Title _____9. Date Person Last Worked _____

10. Date Employment Terminated (if different from 9.) _____

11. If (9) and (10) differ, please explain _____

12. Amount of Critical Illness Insurance in force, applicable to this Insured, under the Policy on date of termination of insurance coverage:

Employee: $ _____ Spouse, if any: $ _____ Child(ren), if any: $ _____

13.Verified by _____
(Signed by authorized individual) Date Phone Number

To Be Completed By Applicant

Name _____ Spouse's Name _____

Address _____
(Street) (City) (State) (Zip)

Date of Birth: Employee: _____Spouse, if any_____ Child(ren), if any _____

Amount of Critical Illness Coverage Desired (must be equal to or less than amount in force, applicable to this Insured):
Note: Spouse/Child coverage may only be ported if employee coverage is also being ported; the spouse amount may not exceed the employee amount; child amount maximum is determined by the provisions in the group contract:

Employee: $_____Spouse, if any: $_____Child(ren), if any: $_____

Beneficiary:

Full Name(s)	Relationship	Percent of Proceeds	SSN
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____
Signature of Applicant Email Address Phone Number Date Signed