SYMETRA®
RETIREMENT | BENEFITS | LIFE

Kit de portabilidad del seguro de vida grupal

Protección de seguro de vida después de que termina su cobertura grupal



Su cobertura de seguro de vida grupal—proporcionada por Symetra Life Insurance Company—incluye una disposición llamada portabilidad. Esta le permite continuar su cobertura cuando deje su empleo. Además, no tiene que responder ninguna pregunta médica.

Elegibilidad

Usted es elegible para la cobertura de portabilidad siempre que:

- ✓ La póliza de seguro de vida grupal de su compañía, y la disposición de portabilidad, estén vigentes al momento de la solicitud.
- ✓ No haya alcanzado la Edad Normal de Jubilación del Seguro Social (SSNRA).
- ✓ No esté por ingresar al servicio militar activo.

Cómo funciona la portabilidad

Puede elegir continuar el 50%, 75% o 100% del monto actual de su beneficio de seguro de vida. Asegúrese de considerar cuidadosamente todas sus necesidades de seguro de vida: si decide portar un porcentaje reducido del monto actual de su beneficio, no podrá continuar ninguna parte del monto restante en una fecha posterior.

La portabilidad también puede estar disponible para su cónyuge y dependientes. Si esta disposición está incluida en la póliza de su compañía, puede seleccionar la cobertura de portabilidad siempre que ellos estén asegurados bajo la póliza de vida grupal vigente en el momento en que termine su cobertura grupal. La cobertura de hijos solo se puede portar si usted o su cónyuge eligen la portabilidad.[1]

Independientemente de lo que elija, el monto del beneficio se redondeará al siguiente múltiplo superior de $1,000 (ejemplo: $125,100 se redondea a $126,000).

	Monto máximo	Monto mínimo
Usted	$250,000	$5,000
Su cónyuge	$50,000	$5,000
Su hijo dependiente	$10,000	$5,000

Esta tabla representa los montos máximos estándar de beneficios. Para obtener más información sobre la póliza de su compañía, hable con su representante de Recursos Humanos.

Preguntas frecuentes

¿Necesito un examen médico?
No. No se requiere un examen médico y no tendrá que responder ninguna pregunta médica.

¿Cuánto cuesta?
El costo real (tarifa) se basa en su edad en el momento en que se aprueba su portabilidad y en si ha usado o no productos de tabaco en los últimos 12 meses. Las tarifas se revisan anualmente y pueden cambiar.

Disposición	Tipo de póliza
Portabilidad	**Seguro de vida a término grupal.** Este tipo de póliza brinda protección hasta alcanzar la edad máxima, siempre que se paguen las primas requeridas. El precio se determina según la edad y tiende a ser más bajo que el de la conversión. La cobertura no permanece asociada a la póliza de seguro de vida grupal que otorgó el derecho a portar. No tiene valor en efectivo.
Conversión	**Seguro de vida permanente individual.** Este tipo de póliza brinda protección de por vida, siempre que se paguen primas suficientes. El precio se basa en tarifas individuales, que tienden a ser más costosas que las de una póliza portada. Esta es una póliza individual, por lo que el empleado es el titular de la póliza en lugar del grupo. La póliza también acumula un valor en efectivo contra el cual se puede pedir prestado, si es necesario.

Mi plan de vida grupal incluye disposiciones de portabilidad y de conversión. ¿Cuál es la diferencia?
La principal diferencia es el tipo de póliza de seguro que recibe (vea la tabla a la izquierda).

Una vez que esté cubierto, ¿el monto de mi beneficio seguirá siendo el mismo?
El monto de su beneficio sigue siendo el mismo cuando porta su cobertura. Sin embargo, el monto del beneficio se reducirá a partir de los 65 años. Comuníquese con su representante de Recursos Humanos para obtener más información.

¿Tendré cobertura de seguro de vida durante el período de portabilidad?
Sí. Sus beneficios de seguro grupal permanecen vigentes durante la transición de 31 días a la póliza portada.

¿Puedo convertir a una póliza individual si mi cobertura se reduce?
Sí, si el monto de su beneficio se reduce debido al calendario de reducción por edad, puede convertir su cobertura portada a una cobertura individual. El costo se basa en su edad en el momento en que solicite la conversión, por lo que elegir portar primero y convertir en una fecha posterior puede afectar el monto de la prima que paga.

Cómo empezar

Para solicitar la portabilidad, complete la Parte A (Part A) de la solicitud adjunta. Su empleador es responsable de completar la Parte B (Part B).

No se demore. Debemos recibir su solicitud y la prima inicial dentro de los 31 días a partir de la fecha en que termine su cobertura grupal.

Envíe su solicitud completada y la prima inicial a:

Symetra Life Insurance Company
P.O. Box 1491
Minneapolis, MN 55480-1491

Cómo empezar

No deje pasar la fecha límite. Complete hoy su solicitud de portabilidad.

Para obtener más información sobre cómo portar su cobertura, hable con su representante de Recursos Humanos.

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
www.symetra.com

Symetra® es una marca de servicio registrada de Symetra Life Insurance Company.

Las pólizas de seguro de vida grupal están aseguradas por Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. El número de formulario de la póliza es LGC-13000 8/06 en la mayoría de los estados y no está disponible en ningún territorio de EE. UU. Nuestra subsidiaria de Nueva York asegura productos para los titulares de pólizas de Nueva York. Las pólizas contienen exclusiones, limitaciones, reducción de beneficios y condiciones para mantenerlas vigentes. Comuníquese con su representante de seguro de vida grupal para obtener todos los detalles.

[1] Los hijos dependientes que hayan alcanzado la edad máxima de emisión no son elegibles para portar su cobertura.

Click here to clear form.

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: PO Box 1491 | Minneapolis, MN 55480-1491
Phone 1-800-426-7784 | TTY/TDD 1-800-833-6388

APPLICATION FOR PORTABILITY CONTINUATION OF GROUP TERM LIFE INSURANCE

Part A: TO BE COMPLETED BY THE APPLICANT "Applicant" means the employee or member of the Group Policy from which coverage is being ported or the employee/member's eligible Spouse as defined in the Group Policy.

IMPORTANT INFORMATION—The enrollment period ends 31 days after the date the Group coverage ends. The application, enrollment form(s) and premium sent to Symetra must be postmarked within this 31 day period. *Submit your first premium with this application to Symetra Life Insurance Company at the above mailing address. Please make your check payable to Symetra Life Insurance Company.*

1. Applicant's Name _____ ☐ Employee/Member ☐ Spouse
2. Address _____

   _____

   Telephone No. Home (_____) _____ Cell (_____) _____

   Premium billing address for Life Insurance, if different than above:

   Address:_____
3. Birth Date _____ (mo-day-year) Sex: ☐ Male ☐ Female
4. Policyholder Name _____ Group Policy No. _____
5. **Important: The minimum and maximum amounts of insurance for which You are eligible are shown in your Group Insurance Certificate. Refer to the "Benefits" section, "Limitations" provision, for specific information.**

   ☐ Yes, I would like to continue my Portability Continuation Basic Life Insurance amount of $_____

   ☐ Yes, I would like to continue my Portability Continuation Supplemental Life Insurance amount of $ _____

   ☐ Yes, I would like to continue my Spouse Life Insurance amount of $ _____ Date of Birth _____ (mo-day-year)

   Spouse's Name *(If the Spouse is not the Applicant)* _____

   ☐ Yes, I would like to continue my Child Life Insurance amount of $ _____

   Child Name _____ Date of Birth _____ (mo-day-year)

   Child Name _____ Date of Birth _____ (mo-day-year)
   (Add additional pages if necessary)
6. Premium Mode: ☐ Quarterly $ _____ ☐ Semi-Annual $ _____ ☐ Annual $ _____
   In order to be eligible for Portability Continuation Insurance, you must submit your first premium with this application to Symetra Life Insurance Company at the mailing address above. Important: Premium modes other than annual are subject to a minimum premium payment of $50.
7. Please provide your last day of active work. _____ (mo-day-year)
8. Are you disabled? ☐ No ☐ Yes If yes, date of disability: from _____ (mo-day-year) to _____ (mo-day-year)
   If yes, have you applied for Waiver of Premium? ☐ No ☐ Yes
   Please note: If you have applied for Waiver of Premium, you may not be eligible for Portability.
   Diagnosis _____
9. Have you used any form of tobacco product within the last 12 months? ☐ No ☐ Yes Spouse? ☐ No ☐ Yes
   (Tobacco product includes cigarettes, cigars, pipes, chewing tobacco, snuff, etc.)

By signing below, I attest that the above information is correct to the best of my knowledge. I also attest that I have read and understand the fraud warning on the following page which applies to me.

Signature of Applicant _____ Date _____ (mo-day-year)

PLEASE HAVE THE GROUP POLICYHOLDER COMPLETE PART B THIS APPLICATION.

FRAUD WARNINGS All Other States: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA: For your protection California law requires the following to appear on this form: any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ID: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IN: Any person who knowingly and with intent to defraud or deceive an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Instructions:
Please fully complete this form and submit with ALL original enrollment cards and any requests for change of beneficiary.

Part B: TO BE COMPLETED BY THE GROUP POLICYHOLDER

"Applicant" means the employee or member of the Group Policy from which coverage is being ported or the employee/member's eligible Spouse as defined in the Group Policy.

1. Symetra Group Policy Number _____ Policyholder Name _____

   Division of _____

   Address _____

2. Applicant's Name _____ ☐ Employee/Member ☐ Spouse
3. Date of hire or membership of employee/member _____ (mo-day-year) Effective date of Applicant's life insurance _____ (mo-day-year)
4. Insurance class _____ Occupation _____
5. Current salary of employee/member (if applicable) $ _____ per ☐ hour ☐ week ☐ month ☐ year
6. Number of hours worked each week (if applicable) _____
7. Date employment or membership terminated _____ (mo-day-year) Last day of active work (if applicable) _____ (mo-day-year)
8. Date through which premiums were paid for this Applicant _____ (mo-day-year)
9. Is the Applicant disabled? ☐ No ☐ Yes If yes, date of disability: from _____ (mo-day-year) to _____ (mo-day-year)
10. Reason for stopping work (if applicable) _____
11. At time coverage terminated under this policy, the following amounts of Life Insurance were in force for each of the following:
    a. Applicant Basic $_____
    b. Applicant Supp $_____
    c. Applicant's Spouse $_____
    d. Applicant's Child(ren) $_____
12. Enrollment verification submitted? ☐ No ☐ Yes
    If no, please explain _____

Important: Applicants who choose to convert their Group Term Life Insurance coverage to an individual policy upon termination of employment are not eligible for Portability Continuation Insurance. Applicants who have applied for Waiver of Premium may not be eligible for Portability.

I hereby certify that: 1) the Applicant was a full-time, permanent, active employee or other eligible member with coverage under the Group Policy; 2) I am not a beneficiary, nor am I related to the beneficiary or the above individual; 3) I am an authorized policyholder representative; and 4) the above statements are true.

Name of person signing _____ Phone No. (___) _____

Email _____ FAX No. (_____) _____

By _____ (Signature) Title _____ Date _____ (mo-day-year)

How to Compute Portability Continuation Insurance Premium

Important: Premium modes other than annual are subject to a minimum premium payment of $50.

Employee Life Insurance

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67
Non Tobacco	$0.090	$0.100	$0.140	$0.210	$0.350	$0.530	$0.880	$1.400	$2.180
Tobacco	$0.170	$0.190	$0.230	$0.350	$0.570	$0.910	$1.430	$2.050	$3.620

To determine your cost for coverage, please determine your rate based on your age above, and then use the following formula(s) to calculate your cost:

$ 100000 (Life Benefit Amount) ÷ 1,000 = $ 100 x $ 0.350 (Rate) = $ 35 (Monthly Premium) x3 = $ _____ (Quarterly Premium)

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ _____ (Rate) = $ _____ (Monthly Premium) x6 = $ _____ (Semi Annual Premium)

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ _____ (Rate) = $ _____ (Monthly Premium) x12 = $ _____ (Annual Premium)

Spouse Life Insurance

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-67
Non Tobacco	$0.090	$0.100	$0.140	$0.210	$0.350	$0.530	$0.880	$1.400	$2.180
Tobacco	$0.170	$0.190	$0.230	$0.350	$0.570	$0.910	$1.430	$2.050	$3.620

To determine your cost for coverage, please determine your rate based on your age above, and then use the following formula(s) to calculate your cost:

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ _____ (Rate) = $ _____ (Monthly Premium) x3 = $ _____ (Quarterly Premium)

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ _____ (Rate) = $ _____ (Monthly Premium) x6 = $ _____ (Semi Annual Premium)

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ _____ (Rate) = $ _____ (Monthly Premium) x12 = $ _____ (Annual Premium)

Dependent Child Life Insurance

Rate	$0.220

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ 0.220 (Rate) = $ _____ (Monthly Premium) x3 = $ _____ (Quarterly Premium)

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ 0.220 (Rate) = $ _____ (Monthly Premium) x6 = $ _____ (Semi Annual Premium)

$ _____ (Life Benefit Amount) ÷ 1,000 = $ _____ x $ 0.220 (Rate) = $ _____ (Monthly Premium) x12 = $ _____ (Annual Premium)

Total Portability Premium

$ _____ (Quarterly Total)

$ _____ (Semi Annual Total)

$ _____ (Annual Total)

Beneficiary Information

Primary Insured _____ Effective Date_____

Symetra Life Insurance Company and the Insured agree as follows:
Symetra Life Insurance Company will make payment to the most recently named beneficiary as shown below.

Primary *(Print each name in full)*

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Contingent *(Print each name in full)*

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Name _____
Address _____
_____
Relationship to Insured _____ Birth Date _____ Percentage(%)_____
mo-day-year

Primary Insured's signature _____ Date _____

Symetra® is a registered service mark of Symetra Life Insurance Company.