Application for Insurance Portability
For Group Long-Term Disability Insurance

Applicant Information

Name of Group Policyholder		**Group No.**
Applicant Name *(Last, First, Middle)*		**Social Security No.**
Street Address		**Phone No.**
City	**State**	**Zip**
Date of Birth	**Gender** Male Female	**Salary at Termination** **$**

You must meet the requirements of the Insurance Portability Endorsement to be eligible.

1. Are you currently insured under any other group long-term disability insurance? Yes No

If "Yes" to the above question, please describe the other insurance:

2. Your employment terminates/terminated on: *(month/day/year)*

3. Specific reasoning for employment termination:

4. Are you currently disabled? Yes No

5. Are you currently on a leave of absence? Yes No

Applicant Agreement

By signing this Application, I understand and agree that:

- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- I understand no insurance will be effective until this Application is approved and the required premium is paid.

WARNING: 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 restitution fines, confinement in prison or any combination thereof.

Applicant Signature	**Date of Signature**

Administered By: North American Benefits Company • 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355