Application for Insurance Portability
For Group Short-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	Salary at Termination
	Male Female	$

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

1. Are you currently insured under any other short-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 on a currently 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

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