Request for portability or retiree life insurance

Group life insurance plan

Employee data (to be completed by employee)

Family name | First name

Date of birth (d/m/y) / / | Sex ◯ M ◯ F

Address

Country | Postal code

Private email | Phone no.

Type of request | ◯ portability* ◯ retiree

* Attach declaration of state of health

Employer data

Please complete the following questions. If your current plan does not include dependent coverage, or the employee is not enrolled, please indicate 'not applicable' (**NA**).

Date individual becomes (became) eligible (d/m/y) / /

Coverage termination date (d/m/y) / /

Reason and date of termination of employment (d/m/y) / /

Salary and date of last day actively at work (d/m/y) / /

Group contract number

Current life coverage amount - Employee

Current life coverage amount - Spouse

Current life coverage amount - Children

I certify that, to the best of my knowledge and belief, the information in this section is correct.

Signature of the employer representative

Family name and first name

Representative phone number | Date (d/m/y) / /

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Employee life insurance coverage (to be completed by the employee)

Please attach beneficiary designation documents. If no beneficiary is known, your estate will be the beneficiary.

Employee (optional term life insurance)

◯ Retain current face amount currency

◯ Elect lower amount currency

Dependent life insurance coverage (to be completed by the employee)

Note: you must elect coverage for yourself in order for your dependants to have coverage. The employee is the beneficiary for dependent life insurance.

Spouse/domestic partner

Family name First name

Date of birth (d/m/y) / /

Child 1

Family name First name

Date of birth (d/m/y) / /

Child 2

Family name First name

Date of birth (d/m/y) / /

Child 3

Family name First name

Date of birth (d/m/y) / /

Do you have any other children, please attach their details to this form.

Employee signature (to be completed by the employee)

I hereby request coverage under the Group Life Insurance Plan. I understand that my Group Life Insurance coverage will be subject to the rules of the group insurance contract.

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

I certify that the above information is to the best of my knowledge and belief correct and true. The issuance of false claims, the provisions of misleading information or the withholding of information related thereto is an offence punishable by Law.

Place

Employee's signature Date (d/m/y) / /

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