Continuation of Group Life Insurance Form
Leaders Life Insurance Company Portability Provision

THIS FORM MUST BE RECEIVED WITHIN 31 DAYS IMMEDIATELY FOLLOWING THE TERMINATION OF EMPLOYMENT.

Administrator:	Bay Bridge Administrator, Inc. P.O. Box 161690 Austin, TX 78716	Attn: Underwriting Phone #: (800) 845-7519 x 402 Fax #: (512) 275-9352

If an Insured ceases to be employed by the Participating Employer for any reason other than retirement, the Insured may elect to continue his or her Life Insurance benefits and the Life Insurance Benefits for his or her Spouse and/or any Dependents then covered under the Policy provided he or she has not attained age 70. The Insured must make such election within 31 days of termination of employment.

SECTION A: TO BE COMPLETED BY INSURED EMPLOYEE			
Date of Request:		Name of Employer	
Group Policy Number		Name of Policyholder	
Insured's Full Name	First:	Middle:	Last:
Insured's Address:	Street:		
City:	State:		Zip Code:
Telephone Number:		Sex: ☐ Male ☐ Female	
Insured's Date of Birth: ____/____/____		Employment Termination Date: ____/____/____	
Insured's Social Security Number:			
Insured's amount of Life Insurance to be continued: _____ (Amount cannot exceed the amount in force on the last day employed by the policyholder. Such amount is subject to any reduction provision shown under the group policy.)			

COMPLETE THE FOLLOWING IF DEPENDENTS ARE INSURED UNDER THE GROUP POLICY

Spouse Full Name:		Amount of Life Insurance Under the Group Policy:	
Date of Birth:		Social Security Number:	
Child(ren) Full Name	Date of Birth	Sex	Amount of Life Insurance Under the Group Policy:
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

I wish to pay premiums ☐ Quarterly ☐ Semi-Annually ☐ Annually
A deposit check must accompany this application. The amount should be equal to the billing selection, which you have chosen.
Make Check Payable to: BayBridge Administrators, Inc.

Send this completed Form and your Check To Hazel Zellmer at **Bay Bridge Administrators, LLC** (ADDRESS NOTED ABOVE)

I hereby agree to continue my life insurance under the group term policy outlined above.

Signature of Applicant:_____ Date:_____

Notation: Continuation of Group Insurance terminates on the earlier of: termination of the group policy; or the age specified under the Continuation of Coverage in the policy; or upon insurance coverage under another group policy.

SECTION B: TO BE COMPLETED BY EMPLOYER:

Employee's current Leaders Life Group Voluntary (only) Insurance Amount under the Group Policy: _____
Employee's Original Effective Date of Insurance: ____/____/____
Employee's Termination Date: ____/____/____ Paid To Date: ____/____/____

Authorized by: _____ Date: ____/____/____
Title: _____ Telephone: (____) _____ - _____
Employer Name: _____

FOR ADMINISTRATIVE USE ONLY

Coverage Verified by (Name)	Telephone:
Administrator:	Fax: