



VERIFICATION OF INSURED PERSON'S ELIGIBILITY TO PORT CRITICAL ILLNESS INSURANCE

To Be Completed By Policyholder/Participating Unit

☐ Male ☐ Female

1. Insured Person's full name _____ (Please Print) 2. Soc. Sec. Number _____

3. Name of Policyholder/Participating Unit _____ 4. Policyholder/Participating Unit No.: VCI _____

5. Branch or Location (if different from 3.) _____

6. Date of Hire: _____ Class: _____

7. Effective Date of Coverage: Employee: _____ Spouse, if any: _____ Child(ren), if any: _____

8. Occupation/Job Title _____ 9. Date Person Last Worked _____

10. Date Employment Terminated (if different from 9.) _____

11. If (9) and (10) differ, please explain _____

12. Amount of Critical Illness Insurance in force, applicable to this Insured, under the Policy on date of termination of insurance coverage:

Employee: \$ _____ Spouse, if any: \$ _____ Child(ren), if any: \$ _____

13. Verified by _____ Date _____ Phone Number _____

(Signed by authorized individual)

<u>To Be Completed By Applicant</u>			
Name _____		Spouse's Name _____	
Address _____			
(Street)	(City)	(State)	(Zip)
Date of Birth: Employee: _____ Spouse, if any _____ Child(ren), if any _____			
Amount of Critical Illness Coverage Desired (must be equal to or less than amount in force, applicable to this Insured): Note: Spouse/Child coverage may only be ported if employee coverage is also being ported; the spouse amount may not exceed the employee amount; child amount maximum is determined by the provisions in the group contract:			
Employee: \$ _____ Spouse, if any: \$ _____ Child(ren), if any: \$ _____			
Beneficiary:			
Full Name(s)	Relationship	Percent of Proceeds	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Signature of Applicant	Email Address	Phone Number	Date Signed