



INSURANCE BENEFITS PROVIDED BY
 RESERVE NATIONAL INSURANCE COMPANY
 P.O. Box 9988 Austin, TX 78766-9988
 Telephone: 844.613.6245 Fax: 844.473.8084
 Email: ProtectGRPPort@MedMutual.com

PORTABILITY ENROLLMENT FORM	
Group Policyholder Name <small>(Employer/Association/Union)</small>	
Group Policy Number	
Certificate ID Number	
Insured's Name	
Insured's Address	
Insured's Phone	
Insured's Email	

Portability is available if the insured is no longer eligible under the group policy. See your Certificate(s) for details.

*If coverage under the group policy is terminated due to nonpayment of the required premium, or due to cancellation or termination of the group policy by Reserve National Insurance Company, portability coverage is not available

PRODUCT COVERAGE			
Accident Expense (AE)	Accident Indemnity (AI)	Cancer (CA)	Critical Illness (CI)

LIST ELIGIBLE PERSONS TO BE COVERED (persons previously covered ONLY) and product requesting to port.							
Last	First	Middle	Relationship to Insured	Product Requested			
				<input type="checkbox"/> AE	<input type="checkbox"/> AI	<input type="checkbox"/> CA	<input type="checkbox"/> CI
				<input type="checkbox"/> AE	<input type="checkbox"/> AI	<input type="checkbox"/> CA	<input type="checkbox"/> CI
				<input type="checkbox"/> AE	<input type="checkbox"/> AI	<input type="checkbox"/> CA	<input type="checkbox"/> CI
				<input type="checkbox"/> AE	<input type="checkbox"/> AI	<input type="checkbox"/> CA	<input type="checkbox"/> CI
				<input type="checkbox"/> AE	<input type="checkbox"/> AI	<input type="checkbox"/> CA	<input type="checkbox"/> CI

UNDERSTAND THAT PORTED COVERAGE WILL TERMINATE AS OUTLINED IN THE CERTIFICATE(S), INCLUDING BUT NOT LIMITED TO NONPAYMENT OF ANY PREMIUM BY THE DUE DATE.

For Accident, Cancer and Critical Illness Coverage:
 THE COVERAGE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY, EITHER SEPARATELY OR IN COMBINATION WITH EACH OTHER, AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.

_____ Signature of Insured	_____ Date
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NOTE: to be enrolled under the portability provision of your certificate(s), this enrollment form and premium must be received within the time period provided in your certificate(s).