

INDIVIDUAL LIFE CONVERSION- REQUEST FOR INFORMATION



This form enables you and your insured dependents to obtain information on any right you may have to purchase an individual life insurance policy within 31 days after your group life coverage ends or is reduced because of termination of employment or a change in your classification. Please complete the below, if you are interested, and an application and premium costs will be sent. Please note that the application and premium need to be submitted to this office within 31 days after the date of your group life insurance ending.

PART A - EMPLOYER OR ADMINISTRATOR TO CERTIFY

Name of Employee/Member _____	
Name of Employer (use shown in group policy or booklet) _____	Employer's Policy# _____
Employer's Address _____	Contact Name _____
DATE OF GROUP LIFE INSURANCE TERMINATION _____/_____/_____	TOTAL AMOUNT OF GROUP LIFE INSURANCE ON TERMINATION DATE: \$ _____

Member's Occupation _____ Class: _____ Member's Hire Date ____/____/_____

Member's effective date of Group Life Insurance Coverage under the Group Policy: ____/____/_____

Did member have Dependent Life Insurance on Group Plan Yes No

Amount of Spouse Life Insurance \$ _____ Amount of Child Life Insurance \$ _____

REASON FOR TERMINATION:

EMPLOYEE	DEPENDENT
<input type="checkbox"/> Termination of Policy	<input type="checkbox"/> Termination of Policy
<input type="checkbox"/> Termination of Employment	<input type="checkbox"/> Divorce
<input type="checkbox"/> Disability	<input type="checkbox"/> Marriage of a child
<input type="checkbox"/> Other (please explain) _____	<input type="checkbox"/> A surviving spouse or child of deceased employee
	<input type="checkbox"/> Other (please explain) _____

Is Employee/Member disabled? Yes No

Is Employee/Member on Disability? Yes No If Yes, did he/she become disabled prior to age 60? Yes No

Has the insured Member made an Absolute Assignment of the group life insurance to be converted? Yes No

If yes, please attach a copy of the Absolute Assignment form.

Date on which this Notice was given to Employee/Member ____/____/_____

Date Notice Completed	Signature of Employer/Administrator	Title	Phone Number
-----------------------	-------------------------------------	-------	--------------

PART B - TO BE COMPLETED BY EMPLOYEE REQUESTING CONVERSION INFORMATION

Name	Social Security #	Date of Birth	Age	Sex
Home Address Street	City	State	Zip Code	

If Spouse or Children are checked above, provide information below:

____ Yourself ____ Spouse ____ Children

Name of Dependent(s)	Age	Date of Birth	SS#	Sex	Relationship to you

Employee's Signature _____ Date Completed and Mailed _____

Mail form to: **HRMP**
Life Conversion Facility
5 Hutchinson Drive
Danvers, MA 01923

TOLL FREE # (888) 999-4767
Phone # (978) 762-0661
Fax # (978) 762-4767

*Upon receiving this form we will send you information, premium rates and application form. *Please note that this form must be filled out by your Employer to receive information and should be in this office within 31 days of your coverage terminating.