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 information below, if you are interested, and an application and premium costs will be sent. Your application and premium need to be submitted to this office within 31 days after the date of your group life insurance ending. **Please review the Conversion Privilege provision in your existing Policy (or if unavailable contact the Employer) to ensure an understanding of your conversion rights, responsibilities and any extension to convert that may be available in your state.**

PART A – EMPLOYER OR ADMINISTRATOR TO CERTIFY

Name of Employee/Member	
Name of Employer:	Employer's Policy #
Employer's Address	Contact Name
Date Of Group Life Insurance Termination (MM/DD/YY)	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

- ☐ Termination of Policy
- ☐ Termination of Employment
- ☐ Disability
- ☐ Other (please explain)_____

_____

DEPENDENT

- ☐ Termination of Policy
- ☐ Divorce
- ☐ Marriage of a child
- ☐ A surviving spouse or child of deceased employee
- ☐ Other (please explain) _____

_____

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 _____
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 received information and should be in this office within 31 days of your coverage terminating.

Mail form to: **HRMP**, Life Conversion Facility, 300 Rosewood Drive, Suite 250, Danvers, MA 01923
TOLL FREE: (888) 999-4767 Phone: (978) 762-0661 Fax: (978) 762-4767