

# 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 (use name shown in group policy or booklet):		Employer's Policy #
Employer's Address		Contact Name
Date Of Group Life Insurance Termination (MM/DD/YY) ____/____/____	Last Day Worked ____/____/____	Total Amount of Group Life Insurance on Termination Date: Basic \$ _____ / Supplemental \$ _____

Member's Occupation \_\_\_\_\_ Class: \_\_\_\_\_ Annual Salary \_\_\_\_\_

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
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## 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	
Phone # ( )	Email Address (If Email address is provided, correspondence will be sent via email:			

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

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, 300 Rosewood Drive, Suite 250, Danvers, MA 01923  
TOLL FREE: (888) 999-4767 Fax: (978) 762-4767 Email: [Conversions@HRMP.com](mailto:Conversions@HRMP.com)