

Life Conversion Request For Information Form



This form enables you and your insured dependents to have the right 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 name 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
<input type="checkbox"/> Termination of Policy
<input type="checkbox"/> Termination of Employment
<input type="checkbox"/> Disability
<input type="checkbox"/> Other (please explain) _____ | DEPENDENT
<input type="checkbox"/> Termination of Policy
<input type="checkbox"/> Divorce
<input type="checkbox"/> Marriage of a child
<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
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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 # () _____

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 - Request for Information
 5 Hutchinson Drive
 Danvers, MA 01923
 Toll free# (888) 999-4767
 Phone# (978) 762-0661
 Fax# (978) 762-4767

* Please note that this form must be filled out by your Employer to receive information.
 The application and first premium must be received by HRMP within 31 days from the termination of your life insurance benefits, under your employer's group insurance policy.