Individual Life Conversion Request For Information Form

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	**Madison National Life Insurance Company**
Name of Policyholder (use name shown in group policy or booklet)	Policy#
Policyholder's Address	Contact Name

DATE OF GROUP LIFE INSURANCE TERMINATION _____/_____/_____	**LAST DATE WORKED** _____/_____/_____	**TOTAL AMOUNT OF GROUP LIFE INSURANCE ON TERMINATION DATE** Basic $_____ Supplemental $_____

If the Employee's/Member's insurance was extended beyond the last date worked please indicate the reason for extension:

_____

_____

Employee/Member's Occupation_____Class:_____ Annual Salary $_____

Employee/Member's Hire Date ___/___/___ Employee's/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 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	Soc Sec #	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:

___Yourself ___ Spouse ___ Children

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

Employee's Signature_____ Date Completed and Mailed_____

Mail to: HRMP Life Conversion Facility, 300 Rosewood Drive, Suite 250, Danvers, MA 01923
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