Request for Group Life Conversion Information

Instructions:

Policyholder (employer): This form should be completed and furnished to every employee who may have the conversion right.

Employee (person requesting information): Complete the employee section and immediately mail to the address to the right.

Attn: Group Life Conversions
P.O. Box 182361
Columbus, Ohio 43218-2361
Phone no. 800-801-6142
Fax no. 614-433-8316

Section 1: To be completed by employer

Group policyholder or plan name			Group no.	Class no.
Employee last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed			Spouse date of birth
Job title			Annual salary $	Certificate no.
Effective date of coverage	Date last worked	Employment termination date		Insurance termination date

Reason for termination

☐ Termination of employment ☐ Reduction of coverage ☐ Death of employee – Spouse name: _____

☐ Termination of group policy ☐ Retirement ☐ Other (specify): _____

Coverage terminating:

Employee		Dependents		
Basic amount	$ _____	Spouse amount	$ _____	Spouse name: _____
Supplemental amount	$ _____	Children (each) amount	$ _____	
Other	$ _____	Child name: _____		Date of birth:
Total amount	$ _____	Child name: _____		Date of birth:
		Child name: _____		Date of birth:
		Child name: _____		Date of birth:

Is the employee/member on disability?	☐ Yes ☐ No	This form will be handed to employee on
If yes, did he/she become disabled prior to age 60?	☐ Yes ☐ No	
Is the employee/member disabled?	☐ Yes ☐ No	This form will be mailed to employee on
Has the insured member made an absolute assignment of group life insurance to be converted?	☐ Yes ☐ No	
If yes, please attach a copy of the absolute assignment form.		

Employer representative signature X	Print name	Title	Date signed (MMDDYYYY)

Company street address	City	State	ZIP code	Company phone no.

Section 2: To be completed by employee

Do not mail this form to the Insurance Company* unless the top portion is completed and signed by employer. Your Group Term Life Insurance Benefits are terminating as indicated above. You may be eligible to convert to an individual life policy. After you promptly send this form to the Insurance Company, we will send you a description of the conversion plan, your premium rates and an application form. The application and first premium payment must be received by the Insurance Company within 31 days of the termination of your life insurance benefits, under your employer's group insurance policy.

Important notice: This is not an application for conversion of your group life plan coverage. Receipt of this form and subsequent information does not guarantee your eligibility to convert your group term life insurance.

Requestor last name	First name	M.I.	Relationship to employee	Phone no.	
Street address			City	State	ZIP code

Requestor signature X	Date signed (MMDDYYYY)

*Used herein, 'Insurance Company' means: Anthem Life Insurance Company, Anthem Life & Disability Insurance Company, Anthem Blue Cross Life and Health Insurance Company, Greater Georgia Life Insurance Company, UniCare Life & Health Insurance Company.

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