

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 \$ _____
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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
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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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