NOTICE OF CONVERSION PRIVILEGE

Information for the Employee

Insurance coverage for your Long Term Disability plan is being terminated as of the DATE OF GROUP COVERAGE TERMINATION shown on the reverse side. You may have the right to CONVERT your Group Long Term Disability coverage without having to submit evidence of good health. Your group insurance certificate or booklet contains the specific conversion privilege.

To receive a cost and benefit quotation for CONVERTED coverage:

1. Complete all information requested in Part B of this form. Part A should have been completed by the employer or administrator. Both Part A and B must be completed and signed before a quote may be given. Retain Page 2 for your records.

2. Mail Page 1 directly to: **Hartford Life**
ATTN: Group Conversion Unit
P.O. Box 2999
Hartford, CT 06104-2999

Conversion rights will expire unless the completed form is received by HARTFORD LIFE within;

a. 31 days from the **Date of Group Termination**, or

b. 15 days from the date the NOTICE OF CONVERSION PRIVILEGE is given to you, whichever is later.

In no event, will item b. extend your right to apply for conversion beyond 91 days after the **Date of Group Coverage Termination.**

If you have any questions on how to complete this form, you may call the Conversion Unit at (800) 548-5157.

NOTICE OF CONVERSION PRIVILEGE

Information for Policyholder or Administrator

Many states have laws requiring the group policyholder to notify covered individuals of any conversion rights when such individuals' coverage is terminating. Failure to do so could impact the individual's right to convert and expose you to legal action.

There is no conversion right when the group policy or plan is cancelled or terminated for any reason.

TO GIVE PROPER NOTICE OF CONVERSION RIGHTS

1. Complete Part A, answering all questions; making certain to include date and signature. Do this no later than 10 days from the termination of coverage.

   The amount that may be converted is determined by multiplying the terminating employee's basic rate of monthly earnings insured under your plan by the lessor of (a) the benefit percentage under your plan or (b) 60%. The converted benefit will be the lessor of the above calculation or $5,000.00.

2. Give pages 1 & 2 to the terminating individual, or mail to his/her last known address.

3. Retain page 3 for your records.

4. If you have any questions on how to complete this form, you may call the Conversion Unit at (800) 548-5157.

Clear Form

PART A: NOTICE OF CONVERSION PRIVILEGE

FOR LONG TERM DISABILITY

THE HARTFORD

EMPLOYER OR ADMINISTRATOR TO COMPLETE THIS PART

Name of Employee/Member	Occupation or position when employed
Name of Policyholder (use name shown in group policy or booklet)	☐ Class 1 ☐ Class 2
Name of participating employer or subsidiary (if different from policyholder)	**Class 1:** Active Full Time Employee who did only tasks which were administrative, sales, clerical or supervisory.
Group Policy Number(s) / Date employee's group coverage terminated	**Class 2:** Any other Active Full Time Employee

THIS INDIVIDUAL IS: (check one) ☐ A terminating employee ☐ No longer in an eligible class ☐ A retiring employee

Was the individual covered under your present or your present and your prior Group Long Term Disability Plan for at least 12 months?

☐ Yes ☐ No **If NO, CONVERSION IS NOT AVAILABLE**

Was any disability preventing the individual from performing the duties of his occupation at the time of the individual's termination?

☐ Yes ☐ No **If YES, CONVERSION IS NOT AVAILABLE**

What was the individual's last basic monthly earnings insured under your Group Long Term Disability Plan at the time of the individual's group termination? $ _____

The above plan of Group Long Term Disability coverage provided a Benefit Percentage of (circle one) 30%, 40%, 50%, 60%, 66 2/3% or other _____ % subject to a maximum monthly benefit of $ _____.

To the best of my knowledge, the above information is correct and complete.

Date Notice Completed	Signature of Employer/Administrator	Title	Telephone Number ( )

PART B: REQUEST FOR QUOTATION

TO BE COMPLETED BY PERSON REQUESTING CONVERSION INFORMATION

Name	Social Security Number	Age	Date of Birth	Sex

Your permanent Home Address	Street	City	State	Zip Code

Was any disability preventing you from performing the duties of your occupation at the time of your termination?

☐ Yes ☐ No **If YES, CONVERSION IS NOT AVAILABLE**

I understand that:

(1) my converted benefit will be 60% of my last insured basic monthly earnings under the Group Long Term Disability plan from which I am converting, not to exceed a maximum monthly benefit of $5,000.

(2) if said prior plan provided a benefit percentage of less than 60% or a maximum monthly benefit of less than $5,000, I am eligible for only the lessor amounts of the prior plan.

(3) any benefits I receive in the event of a disability claim will be for the Converted Benefit amount **MINUS** any other income benefits to which I may be entitled at the time benefits are claimed.

Requester's Signature _____ Date Completed and Mailed _____

Upon receiving this form, information, premium rates and application/enrollment forms will be sent to you.