Clear Form

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 coverage is terminating. Failure to do so could impact the individual's right to conversion and expose you to legal action. Most group plans allow conversion of life insurance when eligibility under the group is lost. The converted benefits are **NOT** the same as those under the group.

Employee/members and/or dependents lose eligibility under most group plans upon:

1. Termination of employment or membership.

2. Death of employee/member, which may cause the surviving spouse or dependent children to lose eligibility.

3. Divorce of a covered spouse from the employee/member.

4. A covered person reaching a limiting age.

5. Termination of the Plan. **In this event, there may be no conversion rights.**

If you are required to offer continuation, it may be necessary to give the terminating individual Notice of Conversion on two separate occasions:

1. Upon initial loss of eligibility. Any life insurance could be converted at this time.

2. Upon expiration of the continuation period.

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.

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

3. Retain a copy for your records.

4. If you have any questions on how to complete this form, you may call the Conversion Unit at 1-800-548-5157.

NOTICE OF CONVERSION PRIVILEGE

Insurance coverage for you or a dependent 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 Life coverage without having to submit evidence of good health. Your group insurance certificate or booklet contains the specific conversion privilege.

GROUP LIFE INSURANCE may be converted to a plan of individual permanent life insurance. Conversion to term insurance is not available in all states. You may convert any amount up to the benefit level you had under the group plan. Special restrictions and limits apply when coverage on an entire class of employees or members terminates.

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

   In most states, conversion rights will expire unless the completed form is mailed, to The Hartford, within:

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

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

   Except where required by state law, item b. will not 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 1-800-548-5157.

PART A: NOTICE OF CONVERSION PRIVILEGE — LIFE INSURANCE ONLY

THE HARTFORD

EMPLOYER OR ADMINISTRATOR TO COMPLETE THIS PART

Name of Employee/Member

Name of Policyholder *(use name shown in group policy or booklet)*	Group Policy Number(s)	Policy Effective Date

Policyholder Address City State Zip Code

COVERAGE IS TERMINATING ON:

☐ Employee/Member named above
☐ Other ***(name)*** _____

Date of Employee last actively at work:

Date of **Employee/Member** Group CoverageTermination ☐ Check if this date is the expiration of a State-required CONTINUATION

THIS INDIVIDUAL iS:

☐ A terminating employee/member
☐ A divorced spouse of an employee/member
☐ A child who no longer qualifies as a dependent
☐ A surviving spouse or child of deceased employee/member
☐ Other (please explain) _____

Is coverage being terminated on: ☐ Individual or ☐ All Employees or ☐ Class of Employees or Members

LIFE PLAN
COVERAGE CARRIED UNDER GROUP

	Life Amount In Force*		Life Enrollment Date for Contributory Coverage	
	Basic	Supplemental	Basic	Supplemental
Employee/Member ☐ NO ☐ YES	$	$		
Spouse ☐ NO ☐ YES	$	$		
Child ☐ NO ☐ YES	$	$		

***NOTE: If eligible, you may either port or convert your insurance coverage. Please refer to your Plan Booklet for specific information.**

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	Telephone Number	Date of Birth	Sex
		( )		☐ M ☐ F

Home Address Street City State Zip Code

Indicate the Amounts of Life Insurance to be Quoted: Employee/Member $ _____ Dependent $ _____
(You may request more than one amount.) $ _____ $ _____

INDICATE THE PERSONS FOR WHOM YOU WISH TO RECEIVE CONVERSION INFORMATION:

☐ Yourself ☐ Spouse ☐ Children (If spouse or children are checked, provide information below:)

Name of Dependents	Date of Birth	Sex	(If over age 19, is dependent a full-time student?)	Relationship to You
		☐ M ☐ F	☐ Yes ☐ No	
		☐ M ☐ F	☐ Yes ☐ No	
		☐ M ☐ F	☐ Yes ☐ No	
		☐ M ☐ F	☐ Yes ☐ No	

Requestor's Signature _____ Date completed and mailed _____

Mail completed form to: Hartford Life
Attn: Group Conversion Unit
P.O. Box 2999
Hartford, CT 06104-2999

Upon receiving this form and enrollment card(s), we will send you coverage information, premium rates and application forms.

Last Name **First Name**