Individual Life Conversion Request For Information

Instructions

Group Carrier: HCC Life Insurance company

Use this form if you want to exercise your right to purchase an individual life insurance policy after your group life coverage with **HCC Life Insurance Company** ends or is reduced because of termination of employment or a change in

If you are interested:

a) The Employer must complete Part A,

b) The Employee must complete Part B,

c) Mail, or fax the completed form to:

HRMP
Life Conversion
300 Rosewood Drive, Suite 250
Danvers, MA 01923

Toll free# (888) 999-4767
Phone# (978) 762-0661
Fax# (978) 762-4767

If you are determined eligible an application and premium costs will be sent to you.

d) Contact us if you do not hear from us within five (5) days of submitting your request for information.

In order to receive information, this form must be filled out by your Employer (Part A) and the Employee (Part B).

The application and premium must be submitted to HRMP within 31 days after the date of your group life insurance ending.

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	**HCC Life Insurance company**
Name of Employer (use name shown in group policy or booklet)	Employer's Policy#
Employer's Address	Contact Name
DATE MEMBER'S EMPLOYMENT WAS TERMINATED _____/_____/_____	**DATE OF MEMBER'S LAST DAY OF ACTIVE WORK** _____/_____/_____
DATE OF GROUP LIFE INSURANCE TERMINATION _____/_____/_____	**TOTAL AMOUNT OF GROUP LIFE INSURANCE ON TERMINATION DATE** $_____

Member's Occupation_____Class:_____ Member's Hire Date_____/_____/_____
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	**DEPENDENT**
___ Termination of Policy	___ Termination of Policy
___ Termination of Employment	___ Divorce
___ Disability	___ Marriage of a child
___ Other (please explain)_____	___ A surviving spouse or child of deceased employee
_____	___ Other (please explain)_____

Is Employee/Member Disabled? _____Yes_____No If yes, when did Employee/Member become disabled?_____/_____/_____

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 Absoulte 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 # ( )

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_____

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Toll Free: (888) 999-4767 Phone: (978) 762-0661 Fax: (978) 762-4767