



# 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 mail to Anthem Life Insurance Company at the address below within 31 days of the date of termination of group benefits.

### SECTION I - TO BE COMPLETED BY EMPLOYER

GROUP POLICYHOLDER OR PLAN NAME		GROUP NUMBER	CERTIFICATE NUMBER
EMPLOYEE NAME (LAST, FIRST, MI)		DATE OF BIRTH	SEX M F
EFFECTIVE DATE OF GROUP COVERAGE		EMPLOYMENT TERMINATION DATE	INSURANCE TERMINATION DATE
			SPOUSE DATE OF BIRTH

#### Coverage Terminating

**Employee**

Basic Amount \$ \_\_\_\_\_

Supplemental Amount \$ \_\_\_\_\_

Other \$ \_\_\_\_\_

**Total Amount** \$ \_\_\_\_\_

**Dependent Spouse Amount** \$ \_\_\_\_\_

#### Reason for Termination

Termination of Employment

Termination of Group Policy

Reduction of Coverage

Retirement

Death of Employee

Spouse Name: \_\_\_\_\_

Other (Specify): \_\_\_\_\_

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.

THIS FORM WILL BE  HANDED TO EMPLOYEE ON (DATE) \_\_\_\_/\_\_\_\_/\_\_\_\_  MAILED TO EMPLOYEE ON (DATE) \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE

COMPANY TELEPHONE NUMBER

**X**

PRINT NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

### SECTION II - TO BE COMPLETED BY EMPLOYEE

Do not mail this form to Anthem Life 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 by mailing this form within 31 days of such termination.

Complete this form and mail without delay. If you are eligible, Anthem Life Insurance Company, Anthem Life Insurance Company will send you a description of the conversion plan, your premium rates and an application form.

**IMPORTANT NOTICE:** This is not an application for conversion of your group life plan coverage. Receipt of this form does not guarantee your eligibility to convert your group coverage.

REQUESTOR'S NAME (LAST, FIRST, MI)		RELATIONSHIP TO EMPLOYEE	
HOME ADDRESS (NO. & STREET)	CITY	STATE	ZIP
SIGNATURE OF REQUESTOR	DATE	HOME TELEPHONE NUMBER ( )	

Do not enclose payment with this form. Send the entire form, when completed, to the address below.

PLEASE MAIL TO: ANTHEM LIFE INSURANCE COMPANY  
ATTN: GROUP LIFE CONVERSIONS  
P.O. BOX 182361  
COLUMBUS, OHIO 43218-2361

PHONE # 800-801-6142  
FAX # 614-433-8880