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. Employee no longer in an eligible class (i.e. Full time to part time).

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

TO GIVE PROPER NOTICE OF CONVERSION RIGHTS

1. Complete **Part A (page 3)**, answering all questions; making certain to include date and signature. Do this no later than 10 days from the termination of coverage.

2. Give the form **(pages 2-4)** to the individual whose coverage is terminating, or mail to his/her last known address.

3. If you have any questions on how to complete this form, you may call the Conversion Unit at **1-877-320-0484.**

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 following page. You may have the right to CONVERT your Group Life coverage. Evidence of insurability is not required to convert your coverage. 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 preliminary term insurance is available in New York and West Virginia. You may be eligible to 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, or the group policy is terminating.

To receive a cost and benefit quotation for CONVERTED coverage:

1. Complete all information requested in **Part B** of this form **(page 4)**. **Part A (page 3)** should have been completed by the employer or administrator. Both **Part A and B (pg 3 & 4)** must be completed and signed before a quote may be given. Please make a copy for your records.

2. Mail directly to: **Hartford Life**
   Attn: Group Conversion Unit
   P.O. Box 248108
   Cleveland, OH 44124-8108

To be considered eligible for Life conversion coverage, you must request a quotation for coverage in most states ***within***:

a. 31 days from the **Date of Group Coverage Termination,** or
b. 15 days from the date the Notice of Conversion Privilege was signed by the policyholder/employer, ***whichever is later.***

Should your prior employer provide you with the Notice of Conversion Privilege late, item b. above does not generally extend your right to ***apply*** for conversion beyond 91 days after the **Date of Group Coverage Termination.** In New York under certain circumstances, slightly more time may be allowed. Please refer to your Group Policy for specifics. Questions regarding late notification are to be directed to your prior employer.

Failure to comply with the timeliness requirement will result in denial of your request to continue coverage.

If you have any questions on how to complete this form, you may call the Conversion Unit at **1-877-320-0484.**

PART A: NOTICE OF CONVERSION PRIVILEGE

EMPLOYER OR ADMINSTATOR TO COMPLETE THIS PART (Complete in INK)

This information is required to obtain a quote. Give this completed page along with pages 2 & 4 to the individual whose coverage is terminating.

Name of Employee/Association Member		Employee ID Number
Employer/Policyholder Name Board of Supervisors of LSU and Agricultural and Mechanical College	Group Policy Number(s) 395208	Policy Effective date 07-01-2009
Campus Code		
Campus Address City State Zip Code		
Date Employee/Association Member last actively worked Full time	Employee/Association Member Coverage Termination Date	☐ Check if this date is the expiration of a State-required CONTINUATION

COVERAGE IS TERMINATING ON:

☐ Employee/Member Named Above ☐ Spouse ☐ Dependent Child

THIS INDIVIDUAL IS:

☐ A terminating Employee/Member

☐ A part time employee

☐ A divorced spouse of an employee/member

☐ Surviving spouse or child of a deceased employee/member

☐ A child who no longer qualifies as a dependent

☐ Active employee losing coverage due to age reduction

REASON FOR TERMINATION OF COVERAGE:

☐ End of Illness or Injury Continuation ☐ Disability ☐ Layoff

☐ No longer in a eligible class ☐ Reduction due to Age

Employee/Member Base Annual Earnings $ ____________________

Employee/Member Date of Hire _____________ Group Coverage Paid Through Date _______________

Coverage is being terminated on:

☐ Individual ☐ All employees/members ☐ Class of employees/members

LIFE PLAN COVERAGE CARRIED UNDER GROUP		**Total Life Amount in Force**		**Age Reduction Amount Reduced**	
		Basic	**Supplemental**	**Basic**	**Supplemental**
Employee/Member	☐ Yes ☐ No	$	$	$	$
Spouse	☐ Yes ☐ No	$	$	$	$
Child	☐ Yes ☐ No	$	$	$	$

Date Notice Completed	Signature of Employer/Administrator
Phone Number	Fax Number

PART B: REQUEST FOR QUOTATION

TO BE COMPLETED BY PERSON REQUESTING CONVERSION QUOTES (Complete in INK)
This information is required to obtain a quote. Submit this completed page along with Part A (page 3) to the address below.

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 (you may request more than one amount)

Employee/Association Member $________________ $________________$________________

Dependent(s) $______________ $________________ $________________ $________________

$______________ $________________ $________________ $________________

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		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
Employee Signature **(Required)**			Date Signed	

<u>Mail Completed form (page 3 & 4)</u> to: **Hartford Life**
Attn: Group Conversion Unit
P.O. Box 248108
Cleveland, OH 44124-8108

Upon receiving this form we will send you coverage information, premium rates, and enrollment forms.

Please Note: Quotes are based on the information provided on this form. Evidence of insurability is not required to convert your coverage, however, prior to policy issuance an eligibility check will be performed to determine the amount of coverage that may be converted.