Individual Life Conversion Request For Information Form

HRMP®
Member ARAN Insurance Services Group

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	**LifeMap Assurance Company**
Name of Employer (use name shown in group policy or booklet) Granite School District	Employer's Policy# UT 00511 U
Employer's Address 2500 South State Street, Salt Lake City, Ut 84115	Contact Name Berkley King/Colleen Lynch

DATE OF GROUP LIFE INSURANCE TERMINATION	LAST DATE WORKED	TOTAL AMOUNT OF GROUP LIFE INSURANCE ON TERMINATION DATE
_____/_____/_____	_____/_____/_____	Basic $_____ Supplemental $_____

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
___ Termination of Policy
___ Termination of Employment
___ Disability
☐ Other (please explain)_____
_____

DEPENDENT
___ Termination of Policy
___ Divorce
___ Marriage of a child
___ A surviving spouse or child of deceased employee
☐ Other (please explain)_____
_____

Is Employee/Member Disabled? ☐ Yes ☐ No

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.

Date on which this Notice was given to Employee/Member _____/_____/_____

Date Notice Completed	Signature of Employer/Administrator	Title	Phone Number
		Benefit Secretary	385.646.5000

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 # ( ) **Email Address:**

If Email address is provided correspondence will be sent via email.

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_____

Mail to: HRMP Life Conversion Facility, 300 Rosewood Drive, Suite 250, Danvers, MA 01923
Toll Free: (888) 999-4767 Phone: (978) 762-0661 Fax: (978) 762-4767 Email: Conversions@HRMP.Com