

## NOTICE OF CONVERSION PRIVILEGE

### Information for the Employee

Insurance coverage for your Long Term Disability plan 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 Long Term Disability coverage without having to submit evidence of good health. Your group insurance certificate or booklet contains the specific conversion privilege.

#### 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. Make a copy for your records.
2. Mail directly to:  
**Hartford Life**  
**Attn: Group Conversion Unit**  
**P.O. Box 248108**  
**Cleveland, OH 44124-8108**

**Conversion rights will expire** unless the completed form is received by HARTFORD LIFE within;

- a. 31 days from the **Date of Group Termination**, or
- b. 15 days from the date the NOTICE OF CONVERSION PRIVILEGE is given to you, whichever is later.

In no event, will item b. 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 **1-877-320-0484**.

## **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 such individual's coverage is terminating. Failure to do so could impact the individual's right to convert and expose you to legal action.

There is no conversion right when the group policy or plan is cancelled or terminated for any reason.

#### **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.

The amount that may be converted is determined by multiplying the terminating employee's basic rate of monthly earnings insured under your plan by the lessor of (a) the benefit percentage under your plan or (b) 60%. The converted benefit will be the lessor of the above calculation or \$5,000.00 .

2. Give to the terminating individual, 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

**PART A: NOTICE OF CONVERSION PRIVILEGE  
FOR LONG TERM DISABILITY**



**EMPLOYER OR ADMINISTRATOR TO COMPLETE THIS PART**

Name of Employee/Member		Occupation or position when employed	
Name of Policyholder (use name shown in group policy or booklet)		<input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2	
Name of participating employer or subsidiary (if different from policyholder )		<b>Class 1:</b> Active Full Time Employee who did only tasks which were administrative, sales, clerical or supervisory.	
Group Policy Number(s)	Date employee last actively at work	Date employee's group coverage terminated	<b>Class 2:</b> Any other Active Full Time Employee

THIS INDIVIDUAL IS: (check one)     A terminating employee     No longer in an eligible class     A retiring employee

Was the individual covered under your present or your present and your prior Group Long Term Disability Plan for at least 12 months?  
 Yes     No    **if NO, CONVERSION IS NOT AVAILABLE**

Was any disability preventing the individual from performing the duties of his occupation at the time of the individual's termination?  
 Yes     No    **if YES, CONVERSION IS NOT AVAILABLE**

What was the individual's last basic monthly earnings insured under your Group Long Term Disability Plan at the time of the individual's group termination?    \$ \_\_\_\_\_

The above plan of Group Long Term Disability coverage provided a Benefit Percentage of (circle one) 30%, 40%, 50%, 60%, 66 2/3% or other \_\_\_\_\_ % subject to a maximum monthly benefit of \$ \_\_\_\_\_.

To the best of my knowledge, the above information is correct and complete.

Date Notice Completed	Signature of Employer/Administrator	Title	Telephone Number (    )    _____
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**PART B: REQUEST FOR QUOTATION**

**TO BE COMPLETED BY PERSON REQUESTING CONVERSION INFORMATION**

Name	Social Security Number	Age	Date of Birth	Sex
Your permanent Home Address	Street	City	State	Zip Code

Was any disability preventing you from performing the duties of your occupation at the time of your termination?  
 Yes     No    **if YES, CONVERSION IS NOT AVAILABLE**

I understand that:

- (1) my converted benefit will be 60% of my last insured basic monthly earnings under the Group Long Term Disability plan from which I am converting, not to exceed a maximum monthly benefit of \$5,000.
- (2) if said prior plan provided a benefit percentage of less than 60% or a maximum monthly benefit of less than \$5,000, I am eligible for only the lessor amounts of the prior plan.
- (3) any benefits I receive in the event of a disability claim will be for the Converted Benefit amount **MINUS** any other income benefits to which I may be entitled at the time benefits are claimed.

Requester's Signature \_\_\_\_\_ Date Completed and Mailed \_\_\_\_\_

Upon receiving this form, information, premium rates and application/enrollment forms will be sent to you.