

# 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 immediately mail to Anthem Blue Cross Life and Health Insurance Company.

Attn: **GROUP LIFE CONVERSIONS**  
 P.O. Box 182361  
 Columbus, Ohio 43218-2361  
 Phone no. 800-801-6142  
 Fax no. 614-433-8316

### Section 1. TO BE COMPLETED BY EMPLOYER

Group policyholder or plan name		Group no.	Class no.
Employee name		Social Security No.	Date of birth
Job title		Annual salary \$	Certificate no.
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Spouse date of birth
Effective date of coverage	Date last worked	Employment termination date	Insurance termination date
Reason for termination <input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction of coverage <input type="checkbox"/> Death of employee <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Termination of group policy <input type="checkbox"/> Retirement <input type="checkbox"/> Spouse name _____			
Coverage terminating: <b>Employee</b>		<b>Dependents</b>	
Basic amount	\$ _____	Spouse amount	\$ _____
Supplemental amount	\$ _____	Children (each) amount	\$ _____
Other	\$ _____		
Total amount	\$ _____		
Is the employee/member on disability? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did he/she become disabled prior to age 60? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Is the employee/member disabled? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Has the insured member made an absolute assignment of group life insurance to be converted? .... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach a copy of the absolute assignment form.			This form will be handed to employee on _____ This form will be mailed to employee on _____
Employer representative signature <b>X</b>		Print name	Title
Company address		Company phone no.	

### Section 2. TO BE COMPLETED BY EMPLOYEE

Do not mail this form to Anthem Blue Cross Life and Health 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. After you promptly send this form to Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross Life and Health Insurance Company will send you a description of the conversion plan, your premium rates and an application form. The application and first premium payment must be received by Anthem Blue Cross Life and Health Insurance Company within 31 days of the termination of your life insurance benefits, under your employer's group insurance policy.

**Important notice:** This is not an application for conversion of your group life plan coverage. Receipt of this form and subsequent information does not guarantee your eligibility to convert your group term life insurance.

Requestor name	Relationship to employee	Phone no.	
Address (no. and street)	City	State	ZIP code
Requestor signature <b>X</b>	Date signed		

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningún costo adicional llamando al número de servicio al cliente que se encuentra en este documento.