

NOTICE OF CONVERSION PRIVILEGE FOR LONG TERM DISABILITY

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 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 lesser of:

- (a) the benefit percentage under your plan or,
- (b) 60%.

The converted benefit will be the lesser of the above calculation or \$5,000.00

2. Give the form with **Part A** completed 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**.

NOTICE OF CONVERSION PRIVILEGE FOR LONG TERM DISABILITY



Information for the Employee

Insurance coverage for your Long Term Disability plan is being terminated as of the **DATE OF GROUP COVERAGE TERMINATION**. 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 issued.

2. Mail the completed form directly to:

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

Keep a copy for your records.

To be considered eligible for LTD conversion coverage, you must request a quotation for coverage **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 extend your right to **apply** for conversion beyond 91 days after the **Date of Group Coverage Termination**. Questions regarding late notification are to be directed to your prior employer.

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 PLAN ADMINISTRATOR TO COMPLETE THIS PART (Complete in Ink)

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)			Class 1: 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:	Class 2: Any other Active Full Time Employee	

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

A retiring employee - **CONVERSION IS NOT AVAILABLE**

Was the individual covered under your present or your present and 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/her occupation at the time of the individual's termination?

Yes No **IF YES, CONVERSION IS NOT AVAILABLE**

What were 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 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 (Complete in Ink)

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 lesser 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.

Requestor's Signature _____ Date Completed and Mailed _____

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