Notice of Conversion and/or Portability Rights

Important Notice regarding your coverage: If you are an active employee, terminated employee, retiree or dependent who may be faced with losing all coverage or even a portion of your coverage under your employer's Group life plan(s), you and/or your dependents may be eligible to continue the lost amount of coverage without submittingF3 9s3ry9d0utouonnue to0030052e h(A-)4

maximum age limit, you have retired or you have reached the end of an employer sponsored continuation provision. You have options to retain this important coverage that are explained below. The specific options available to you are based on the provisions as defined in the Group plan. Included with this notice is a form you can submit to obtain additional information. You will receive details on the specific coverage options available to you, receive a quote, and the necessary forms to obtain coverage.

Life Conversion

your terminating coverage. Conversion is also available to your dependents if they had coverage under your group plan. You may have the option to obtain a one year term policy prior to the permanent life policy becoming effective. Please refer to The Hartford Group Life policy for information. **Premiums for a Life Conversion policy are substantially higher than your Employer Group plan rates.**

Portability

Under the Portability option you may obtain a group life insurance policy to continue 100%, 75%, or 50% of the amount of life insurance coverage (Basic, Supplemental, or both) you had under your Group plan up to a maximum

r Employer Group plan rates and rates increase every five years (years i n which your age on your birthday ends in 5 or 0).

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Employer:_____ Policy #:_____

The following information is to be completed by Employer or Employer Representative

Employee Name:_____ Employee ID#:_____ Date:_____

Last Day Worked (or date employee is no longer in an eligible class):_____

Date of Group Coverage Termination:_____ Termination Reason:_____

Signature_____ Print Name_____

Email Address_____ Telephone_____

As noted above, Conversion and Portability options are available without submission of evidence of good health. The rates for Life Conversion will be substantially higher than your employer Group plan rates. The rates for Portability are based on the employer's standard industry code and/or Group plan provisions and may be higher than your employer Group rates. Portability rates increase every 5 years (years in which your age on your birthday ends in 5 or 0).

Employee: To request a specific quote and application, please complete the information below and mail or fax this entire page to:
The Hartford, Portability and Conversion Unit, P.O. Box 43786, Cleveland, OH 44143-0786
Fax 440-646-9339, Phone 877-320-0484

Yes, I am interested in receiving the information checked below.
☐ 12 month Term/Whole Life Conversion Quote/Application (12 month only available for groups sitused in NY & WV)
☐ Portability Term Life Quote/Application

Please print the following information:

Name:_____ Date of Birth:_____

Social Security # **(indicate last 4 digits only):**_____

Address:_____

City:_____ State: _____ Zip Code:_____

Telephone Number:_____ Email:_____

I am interested in receiving information for the following persons:
☐ Myself ☐ My Spouse ☐ My Child(ren)

Please print the name(s), relationship, and date(s) of birth for each dependent who may be eligible for coverage. Include an additional sheet if necessary.

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Please note that there is a designated timeframe during which you can exercise your coverage continuation options. This request must be received by The Hartford within 91 days of the date that group coverage terminates under the employee's former group plan. Requests received more than 91 days after group coverage terminates will be denied. Any issues regarding late notification by your employer must be addressed with the employer.

_____ _____

Signature (required) **Date**