Individual Life Conversion Request For Information Form

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	**Madison National Life Insurance Company**
Name of Policyholder (use name shown in group policy or booklet)	Policy#
Policyholder's Address	Contact Name

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

If the Employee's/Member's insurance was extended beyond the last date worked please indicate the reason for extension:

____

____

Employee/Member's Occupation_______________________________Class:___________________ Annual Salary $_______________________

Employee/Member's Hire Date ___/___/___ Employee's/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

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.

___Yourself ___ Spouse ___ Children

Name of Dependent(s)	Age	Date of Birth	SS#	Sex	Relationship to you

Employee's Signature____ Date Completed and Mailed________________________