RESET

UNICARE®

Request for Group Life Conversion Information

Anthem® Life

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 Life Insurance Company at the address shown below without delay. (See Section II.)

SECTION I – TO BE COMPLETED BY EMPLOYER

GROUP POLICYHOLDER OR PLAN NAME: Semper Fit and Exchange Services Division/Marine Corps NAF

107103 _____ _____ OR _____ _____ _____

GROUP NUMBER | PCC | CLAIM BRANCH | CASE | GROUP | SUFFIX

_____ _____ _____ M O F O _____ _____

EMPLOYEE NAME (LAST, FIRST, MI) | DATE OF BIRTH | CERT. # | SEX | SOC. SECURITY NO. | JOB TITLE

_____ _____ _____ _____ _____ _____

EFF. DATE OF GROUP COVERAGE | ANN. SALARY | DATE LAST WORKED | EMPL. TERMINATION DATE | INSUR. TERMINATION DATE | SPOUSE DOB

Coverage Terminating

- ☐ Employee
  - Basic Amount $_____
  - Supplemental Amount $_____
  - Other $_____
  - Total Amount $_____
- ☐ Dependent Spouse Amount $_____
- ☐ Dependent Children (each) Amount $_____

Reason for Termination

- ☐ Termination of Employment
- ☐ Termination of Group Policy
- ☐ Reduction of Coverage
- ☐ Retirement
- ☐ Death of Employee
- ☐ Spouse Name:_____
- ☐ Other (Specify):_____

IS EMPLOYEE/MEMBER ON DISABILITY? ○ YES ○ NO IF "YES," DID HE/SHE BECOME DISABLED PRIOR TO AGE 60? ○ YES ○ NO

IS THE EMPLOYEE/MEMBER DISABLED? ○ 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.

THIS FORM WILL BE ○ HANDED TO EMPLOYEE ON (DATE) _____ ○ MAILED TO EMPLOYEE ON (DATE) _____

X_____ _____

SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE | PRINT NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

_____ _____

COMPANY TELEPHONE NUMBER | COMPANY ADDRESS

SECTION II – TO BE COMPLETED BY EMPLOYEE

Do not mail this form to Anthem Life 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 Life Insurance Company, Anthem Life 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 Life 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'S NAME (LAST, FIRST, MI) | RELATIONSHIP TO EMPLOYEE

_____ _____ _____ _____

HOME ADDRESS (NO. & STREET) | CITY | STATE | ZIP

_____ _____ _____

SIGNATURE OF REQUESTOR | DATE | HOME TELEPHONE NUMBER

Do not enclose payment with this form. Send the entire form, when completed, to the address below.

PLEASE MAIL TO: ANTHEM LIFE INSURANCE COMPANY
ATTN: GROUP LIFE CONVERSIONS
P.O. BOX 182361
COLUMBUS, OHIO 43218-2361

PHONE # 800-801-6142
FAX # 614-433-8880

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