



Phone Number: (800) 367-6401

Instructions for Use

The application to convert group life insurance is to be utilized when you become ineligible for group insurance. An example of this would be termination of employment. The application is used to convert your Group Life Insurance coverage to an Individual Whole Life Insurance policy. This can be done regardless of your current health. For information about the amount you may convert or how long you have to convert, see either your certificate or group policy. The application must be filled out by both your employer and yourself.

Part 1 - To be filled out by the Employer

- Ensure the Amount of insurance is filled out for each applicable product (Basic Life, Supplemental Life, Voluntary Life, etc) eligible for conversion.
- Specify clearly the reason for termination.
- If an error is made, you may strike the error, but you must initial the change.

Part 2 - To be filled out by the Insured/Applicant

- If electing Electronic Funds Transfer (EFT) please ensure that you sign the authorization on the second page of the application and attach a voided check.
- Specify clearly the reason for termination.
- If an error is made, you may strike the error, but you must initial the change.
- If applicant is under the age of 20, please contact customer service for applicable rate.

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Upon becoming ineligible for group insurance, e.g., leaving employment, you may convert your Group Life Insurance coverage to an Individual Whole Life Insurance policy. This can be done regardless of your current health. For information about the amount you may convert or how long you have to convert, see either your certificate or group policy.

To apply:

1. Complete Part 2 of this conversion application. Be sure your Employer has completed Part 1. Premium rates and instructions are shown on the reverse side.
2. Mail the completed application with your check or money order for the first modal premium to the above address.

Part 1: TO BE COMPLETED BY EMPLOYER			Group Number	Reason for Termination <input type="checkbox"/> Termination of employment or membership in eligible class <input type="checkbox"/> Termination of Group Policy and Date Term'd. _____ <input type="checkbox"/> Disability <input type="checkbox"/> Other (Specify) _____
Date Employment Term'd. ____/____/____	Date Coverage Terminated	Last Actual Day of Work	Amount of Group Insurance	
Name of Employer Providing Group Policy		Annual Salary \$	Insurance Class	
Signature of Policyholder's Representative/Title		Telephone Number ()	Date Signed	

Part 2: TO BE COMPLETED BY INSURED Please type or print with ball point pen					
I hereby apply to convert my life insurance and affirm the following statements of fact:					
NAME IN FULL		SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ()	GROUP POLICY NO.
RESIDENT ADDRESS					
STREET		CITY		STATE	ZIP CODE
SEX	DATE OF BIRTH ____/____/____	AGE LAST BIRTHDAY	STATE OF BIRTH	LAST DATE OF ACTIVE WORK MO DAY YR	PRESENT OCCUPATION
AMOUNT OF INSURANCE TO BE CONVERTED		PREMIUM MODE <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> EFT Monthly*		First full modal premium must be submitted with application Premium Enclosed \$ _____	
					Automatic Premium Loan Provision Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
BENEFICIARY DESIGNATION					
FIRST NAME		LAST NAME		ADDRESS	SOCIAL SECURITY NO.
DATE OF BIRTH		RELATIONSHIP			
Primary					
Secondary					
If more space is needed 1) use extra paper 2) mark above "See Attached" 3) attachment MUST be signed and dated by Policy Owner.					
Is the owner to be other than the insured? <input type="checkbox"/> Yes <input type="checkbox"/> No					
First Name		Initial	Last Name		Relationship
Address of Owner, if other than Insured:					
No. & Street		City		State	ZIP Code
The Owner is the person who may exercise all rights in the contract, e.g., assign, surrender, borrow. If no one is named, the Insured shall be the Owner.					
I declare that the information on this application is complete and true, to the best of my knowledge and belief. I agree that the Company may deposit the payment submitted with this application prior to approval of this application. If I am not eligible to convert my Group Insurance, the sole obligation of the Company shall be to refund any premiums paid.					
Signed At _____		on ____/____/____			
City		State		Mo Day Year	
				Signature of Applicant	
*EFT (Electronic Funds Transfer – Sign on back and attach voided check)				Signature of Owner (Other than Insured)	

Premiums are payable to age 98 or death, whichever occurs first. For information about the amount you are eligible to convert, please refer to the Conversion of Life Insurance provision of your group life insurance certificate or the group policy. Our minimum issue amount is \$2,000.

To calculate your premium, find your present age and the corresponding **table rate per \$1,000** from the columns below. Multiply this premium by the number of thousands of dollars of insurance you plan to convert. Then multiply by the premium factor and add the modal policy fee to find your premium payment.

Last Birthday	Table Rate Per Thousand	Last Birthday	Table Rate Per Thousand
20	6.51	60	47.79
21	6.86	61	50.70
22	7.09	62	53.72
23	7.42	63	56.86
24	7.76	64	60.23
25	8.10	65	63.84
26	8.56	66	67.67
27	8.90	67	71.74
28	9.22	68	76.05
29	9.68	69	80.47
30	10.13	70	85.24
31	10.58	71	90.70
32	11.03	72	96.55
33	11.59	73	102.77
34	12.14	74	109.38
35	12.70	75	116.41
36	13.25	76	123.90
37	13.92	77	131.94
38	14.58	78	140.61
39	15.23	79	150.02
40	15.89	80	160.20
41	16.77	81	171.21
42	17.76	82	183.01
43	18.73	83	195.57
44	19.71	84	208.90
45	20.79	85	223.10
46	21.97	86	282.86
47	23.14	87	342.62
48	24.53	88	402.38
49	25.90	89	462.15
50	27.36	90	521.91
51	28.92	91	581.67
52	30.56	92	641.43
53	32.28	93	701.19
54	34.10	94	760.95
55	36.10	95	820.72
56	38.10	96	880.48
57	40.30	97	940.24
58	42.68	98	1,000.00
59	45.16		

(✓)	Mode Desired	Premium Factor	Modal Policy Fee
()	Annual	1.000	\$17.00
()	Semi-Annual520	\$ 9.00
()	Quarterly265	\$ 5.00
()	EFT Monthly08583	\$ 0.00

(Sign below & attach voided check)

Enclose the **Modal Premium** amount with your application.

For clarification, contact
DEARBORN LIFE INSURANCE COMPANY
Attn: Department 6006
1020 31st Street
Downers Grove, IL 60515
1-800-367-6401

EFT Authorization: Check one:

Checking **Savings**

Account # _____

I hereby authorize and request Dearborn Life Insurance Company to withdraw funds from my account and transfer those funds in payment for my monthly premium, and to initiate debit entries, if necessary, for any credit entries made in error. This authorization is to remain in full force until I notify Dearborn Life Insurance Company in writing of any changes or cancellation of payment. I understand that to change or cancel any future transactions, such notice must be received not less than ten business days prior to the transaction date.

Signature of Account Holder

(Please attach voided check)

Example: Conversion of \$10,000 Group Life for a 45-year old to \$10,000 Whole Life Plan payable quarterly:

Example:

Table Rate	X	# of Thousands To Be Converted	X	Premium Factor	+	Modal Policy Fee	=	Modal Premium
20.79	X	10.000	X	0.265	+	5.00	=	\$60.10

Your Calculations

Table Rate	X	# of Thousands To Be Converted	X	Premium Factor	+	Modal Policy Fee	=	Modal Premium
_____	X	_____	X	_____	+	_____	=	\$ _____



The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading material facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading material facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine & Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars(\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.



The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.