



# MEDMUTUAL LIFE®

A Medical Mutual Company

100 American Road

Cleveland, OH 44144-2322

Telephone: 866-925-2542 Email: PolicyAdmin@Medmutual.com

## APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE

Upon becoming ineligible for group insurance, you may be eligible to convert all or part of your Group Life Insurance coverage to an Individual Whole Life Insurance policy regardless of any current health conditions. For information concerning your eligibility for conversion refer to your certificate or Summary Plan Description (SPD).

### 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 page 3.
2. Mail the completed application **with your check or money order** for the first premium to: MedMutual Life Insurance Company, 100 American Road, Cleveland, OH 44144-2322.
3. EFT Authorization may be set up following the first premium received by check or money order. Please fill out the EFT authorization box on page three. Sign and date the application.

<b>PART 1: TO BE COMPLETED BY EMPLOYER</b>				Employer	Group Number	<b>Reason for Termination</b> <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) _____
Employee Name		Annual Salary		Insurance Class		
Date Employment Term'd	Date Coverage Terminated	Last Actual Day of Work		Total Amount of Group Insurance		
Does <b>Applicant</b> have:		Basic Life?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$	_____	
		Basic Dependent Life?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$	_____	
		Supplemental/Voluntary Life?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$	_____	
Signature of Employer Representative/Title			Telephone Number (    )		Date Signed	

<b>PART 2: TO BE COMPLETED BY INSURED</b>			
I hereby apply to convert my life insurance and affirm the following statements of fact:			
APPLICANT NAME (Last, First, MI)		SOCIAL SECURITY or MMO ID	TELEPHONE NUMBER (    )
EMPLOYEE NAME (Last, First, MI)		SOCIAL SECURITY or MMO ID	TELEPHONE NUMBER (    )
			GROUP POLICY NO.
ADDRESS			
STREET	CITY	STATE	ZIP CODE
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH / /	LAST DATE OF ACTIVE WORK MO    DAY    YR	E-MAIL
SPOUSE NAME (Last, First, MI)		SPOUSE GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SPOUSE DATE OF BIRTH / /
PREMIUM PAYABLE: <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly		<b>First full premium must be submitted with application</b>  Premium Enclosed \$ _____	

<b>COVERAGE SELECTION:</b>			
Basic Coverage(s)		Total Amount of Coverage Applied for	
Basic Employee Life <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____	
Basic Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Spouse \$ _____ Child(ren)	
Supplemental/Voluntary Life <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Applicant \$ _____ Spouse \$ _____ Child(ren)	

BENEFICIARY DESIGNATION	Last Name	First Name	MI	Date of Birth	Relationship	Benefit %
(Primary)				/ /		
(Primary)				/ /		
(Contingent)				/ /		
(Contingent)				/ /		

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must be 100%.

Is the owner to be other than the Insured?  Yes  No

Name of Owner, if other than Insured:

Phone Number of Owner

Email of owner

Address of Owner, if other than Insured:

Street Address

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 MedMutual Life Insurance 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.

WARNING: 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 information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

Signed At \_\_\_\_\_ on \_\_\_\_\_

*City and State*

*Month*

*Day*

*Year*

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Signature of Owner ( Other than Insured)*

# PREMIUM CALCULATION WORKSHEET

## For Conversion from Group Life to Individual Whole Life Policy

Premiums are payable to age 120 or death, whichever occurs first. 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 add a \$90.00 policy fee. Then multiply the sum of the premium and the policy fee by the premium factor to find your modal premium.

Age at Issue Date	Table rate per thousand		Age at Issue Date	Table rate per Thousand	
	Male	Female		Male	Female
0	4.50	4.00	46	41.10	32.36
1	4.74	4.05	47	41.98	33.52
2	4.99	4.10	48	42.86	34.69
3	5.23	4.16	49	43.74	35.85
4	5.48	4.21	50	44.62	37.02
5	5.72	4.26	51	47.54	39.15
6	6.37	4.59	52	50.46	41.27
7	7.02	4.93	53	53.37	43.40
8	7.66	5.26	54	56.29	45.52
9	8.31	5.60	55	59.21	47.65
10	8.96	5.93	56	62.32	49.57
11	10.27	6.43	57	65.43	51.49
12	11.58	6.93	58	68.54	53.42
13	12.88	7.44	59	71.65	55.34
14	14.19	7.94	60	74.76	57.26
15	15.50	8.44	61	80.60	60.62
16	16.24	8.86	62	86.44	63.98
17	16.97	9.28	63	92.28	67.33
18	17.71	9.69	64	98.12	70.69
19	18.44	10.11	65	103.96	74.05
20	19.18	10.53	66	109.25	77.48
21	19.65	11.04	67	114.54	80.91
22	20.12	11.56	68	119.82	84.35
23	20.59	12.07	69	125.11	87.78
24	21.06	12.59	70	130.40	91.21
25	21.53	13.10	71	131.82	92.14
26	21.08	13.34	72	133.24	93.07
27	20.62	13.58	73	134.66	93.99
28	20.17	13.82	74	134.66	93.99
29	19.71	14.06	75	137.50	95.85
30	19.26	14.30	76	154.34	105.29
31	20.17	15.28	77	171.18	114.73
32	21.08	16.27	78	188.02	124.18
33	22.00	17.25	79	204.86	133.62
34	22.91	18.24	80	221.70	143.06
35	23.82	19.22	81	232.25	151.45
36	24.63	19.79	82	242.80	159.84
37	25.44	20.37	83	253.35	168.22
38	26.26	20.94	84	263.90	176.61
39	27.07	21.52	85	274.45	185.00
40	27.88	22.09	86	283.31	192.39
41	30.35	23.91	87	292.17	199.78
42	32.82	25.73	88	301.04	207.17
43	35.28	27.55	89	309.90	214.56
44	37.75	29.37	90	318.76	221.95
45	40.22	31.19			

Modal Premium	Premium Factor
Annual .....	1.000
Semi-Annual .....	.52
Quarterly .....	.275
EFT Monthly .....	.09

**Example:** Conversion of \$10,000 Group Life for a 35-year old male to \$10,000 Whole Life Plan payable semiannually:

**Example:**

Table Rate X # of thousands to be Converted + policy fee of 90.00 X Premium Factor = **Modal Premium**

$$\left[ (\underline{\$23.82} \times \underline{10.000}) + \underline{\$90.00} \right] \times \underline{.52} = \underline{\$170.66}$$

**Your Calculations:**

Table Rate X # of thousands to be Converted + policy fee of 90.00 X Premium Factor = **Modal Premium**

$$\left[ (\underline{\quad} \times \underline{\quad}) + \underline{\$90.0} \right] \times \underline{\quad} = \underline{\quad}$$

### EFT Authorization

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize MedMutual Life Insurance Company to initiate premium deductions from my account. The authorization will remain in effect until MedMutual Life Insurance Company and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from :  Checking  Savings  
(Please note: Not all Financial Institutions allow deductions from savings account. Please verify this information with your financial institution.)

Name and branch of bank/financial institution \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_

Account Number \_\_\_\_\_

Account Holder's Name \_\_\_\_\_

Transit Routing Number \_\_\_\_\_

Date \_\_\_\_\_

**Please attach a voided check for checking account for a deposit slip for savings account in order for our office to verify the bank information.**