Renaissance®
DENTAL • VISION • LIFE • DISABILITY
PO Box 1596, Indianapolis, IN 46202

Renaissance Life & Health
Insurance Company of America
FLORIDA

NOTICE OF GROUP LIFE CONVERSION PRIVILEGE

To: _____ _____
(Name) (Date of Notice)

_____ _____ _____ _____
(Policy No.) (Certificate No.) (Amt. Life Ins.) (Effective Date)

Your Group Life Insurance Was Terminated (Or Reduced By $_____) as of _____
(Month / Day / Year)

YOU ARE HEREBY NOTIFIED THAT THE ABOVE POLICY CONTAINS A CONVERSION PRIVILEGE WHICH WILL PERMIT YOU, IF ELIGIBLE, TO CONVERT YOUR GROUP LIFE INSURANCE COVERAGE TO THE EXTENT THEREIN PROVIDED, TO AN INDIVIDUAL POLICY OF LIFE INSURANCE.

APPLICATION FORMS AND PREMIUM RATES MAY BE OBTAINED BY COMPLETING THE APPLICABLE SECTIONS ON THE BACK OF THIS FORM AND MAILING AT ONCE TO:

Renaissance Life & Health Insurance Company of America
PO Box 1596, Indianapolis, IN 46202

UNDER THE CONVERSION PRIVILEGE YOU ARE REQUIRED TO MAKE WRITTEN APPLICATION FOR COVERAGE AND PAY THE FIRST PREMIUM WITHIN:

A 31 days from the date of termination (or reduction) shown above, ***OR***

B 15 days from the Date of Notice shown above, whichever is later, provided however, that if this notice is not given within 90 days after the date of termination (or reduction), the time allowed for exercising the conversion privilege shall expire at the end of such 90 days.

Please Refer To Your Certificate For Additional Information About Your Conversion Privilege.

Signed: _____ Date: _____

NOTE TO EMPLOYER—Please Indicate Reason For Termination Of Group Life Insurance:

☐ Termination of Employment.

☐ Termination of Membership in Class Eligible for Insurance.

☐ Voluntary Discontinuance of Required Premium Contributions by Employee.

I Am Interested in Making Application Under the Conversion Privilege for an Individual Life Insurance Policy:

☐ The Conversion Privilege for Individual Life Insurance

THE FOLLOWING INFORMATION SHOULD BE FURNISHED IF REQUESTING CONVERSION:		
Full Name:	**Date of Birth** (Month / Day / Year)**:**	☐ Male ☐ Female
Home Address:		**Home Phone:**

Employee Signature: *X*_____ **Date Signed:**_____

THIS IS NOT AN APPLICATION FOR INSURANCE.
DO NOT SEND MONEY WITH THIS FORM

Renaissance®
DENTAL • VISION • LIFE • DISABILITY