

Conversion of Group Term Life Insurance

Aetna Life Insurance Company

Application and payment of the first premium must be made within the time limit shown in your certificate or policy.

BRIEF DESCRIPTION OF CONVERSION PRIVILEGE

NOTICE OF ELIGIBILITY STATEMENT (To be completed by the Employer)

Subject to the terms of the Group Policy (as described in your group insurance certificate): (1) you may apply for an individual life insurance policy in conversion of your Group Term Life Insurance and (2) the individual policy may be for the same amount which you are losing by termination of your insurance under the Group Policy, or for a lesser amount, depending upon the circumstances of the termination.

No medical examination is required, but application and payment of the first premium must be made within 31 days of the date your Group Term Insurance terminates.

Premiums may be paid annually, semi-annually, or quarterly by direct bill; or monthly by Aetna's Automatic Check Plan (ACP). Premiums may be paid other than annually only if the periodic premium is at least \$15.

1.	Name of Employer			
2.	Group Policy (Control) Number or Employee Policy Number			
3.	Suffix and Account Number (example 12-345)			
4.	Name of Employee			
5.	Employee Social Security Number			
6.	Date life insurance began			
7. a.	Date employment or eligibility terminated			
b.	If totally disabled at this time, please state specific cause			
c.	Last day worked if other than date in 7(a)			
8. a.	Date life insurance canceled (Do not include 31 day extended	coverage period.)		
b.	Reason for cancellation of Group Insurance			-
9. a.	Amount of insurance canceled Supplemental/Optional	Basic	Total	-
b.	Amount of insurance remaining in force (when insurance is reduction rule)	educed due to an age	or retirement	
10.	Beneficiary (Name and Relationship)			
11.a.	Date written notice of conversion right given to employee			
b.	If notice not furnished, show "None Given"			
12.	Complete for Dependent Conversion			
a.	Name of dependent			
b.	Amount of dependent Life Insurance canceled			
13.	Employee Home Telephone Number			
Signati	ure (Employer Authorized Representative)			Date
Addres	SS			Telephone Number
HOME	OFFICE USE ONLY			I
Name				
Group C	ontrol Number			
Regular	Group Life	Claim/Account		
Pooled 0	Group Life	Control/Suffix		Claim/Account
GR-6610	9-4 (2-03)	1		1

WHERE TO SEND YOUR APPLICATION

You should send your application and check or money order for the initial premium to:

Aetna Life Insurance Company Life Conversion Unit 151 Farmington Avenue Hartford, CT 06156-1992

NOTE: Be sure the above NOTICE OF ELIGIBILITY STATEMENT has been completed by the employer.

NOTE: This folder shows premium rates for a non-participating permanent type life insurance plan. It is offered in accordance with the conversion privilege contained in the group policy. The premiums for this plan do not vary based on the sex of the applicant.

If other than the Proposed Insured is to be the policyowner, the person who will be the policyowner should sign the application as Applicant. (Where this occurs, use Section 7 "Additional Information" to designate a contingent policyowner.)



Application For Conversion of Group Term Life Insurance

Aetna Life Insurance Company, Hartford, Connecticut 06156

		ly for a policy of insurance upo life as an employee of	n my life in a	ccordance v	vith the provi	isions of	Group Policy N	umber	•	
1.	Proposed I	Insured (Print Name - First, Initial, Last)	☐ Male ☐ Femal		rth (MM/DD/YYYY)	Place o	f Birth		Telephone	Number
2.	Residence	(Number, Street, City, County, State, Zip)				Social S	Security Number			
3.		nployment terminated with above Day Year		. Occupation	n when emplo	yment te	rminated. Full De	tails.		
C.	What is you	r new occupation? Full Details.								
d.	Name of Ne	ew Employer								
4.	a. Plan Whole Lif	è Insurance		b	o. Amount of lemployment te		(Must not exceed am	ount of te	erm insurance w	rhen
	c. Premiu	nual 🗌 Semi-Annual 🗌 Quarte	erly ACP/ *Complete Dedu	Monthly*		natic Prei	mium Loan Provis	sion ope	erative, if ava	ilable.
	☐ Yes☐ No	the ent the life s," amount \$ under	s," the terms of tire first premietime of the pr	of the receipt um for the proposed insur	are hereby ag olicy is paid v red, nor until t	vithin 30 the term	If "No," no insu days from the da insurance under tends beyond the	ate of th the Gro	his application oup Policy er	on during nds (if
5.		lotices to be sent d at Residence	her							
6.	Primar Unless	ciary (NAME AND RELATIONSHIP TO PRO y otherwise requested herein, paynes, to contingent beneficiaries who	nent is to be m	nade to prima	Contingent	ies who			,	ne
b.	Policyowne	r (Unless otherwise requested, Proposed Insu	red is to be Policyc	wner.)						
be ins wa	elief; (2) issurance on aive any of	ALLY AGREED THAT: (1) the uance of the policy applied for sh my life under the Group Policy; (Aetna's rights or requirements.	all be exchang 3) no person of	ged for all pr other than an	rivileges and b	enefits v	with respect to the	e full ar	mount of terr	m
Si	gned at	(City, State)		on			(Month-Day-Year))		
		ignature - May Not be a Named Ben			X		osed Insured			
,										
-	X _ Print Witne	ess Name	FOR HOME RECEIVED INDIVIDUA	OFFICE US	TO BE	e of Appl	icant (if other tha	n Propo	osed Insured)	
GR-	-89008-APP		DATED						GR-66	5109-4 (2-03)
		OMPLETE OR DETACH UNLE	CON	DITIONAL	RECEIPT					
Noti hear Com the p insur- days its H Hart Com REA	surance on to the state of the	IT IS MUTUALLY AGREED To been made in accordance with the refunded; (2) the effective da receipt, or (b) the date the Group policy, the balance of that premiany insurance provided will con	THAT: (1) no ne terms of the te of insurance Term Insurance may be patinue only for	insurance we Group Police applied for nee ends; and within 60 the period w	ill be effectively referred to will be the L.d (3) if the pay days from the physical the payres.	e unless in the ap ATER or yment is e date of	this application a oplication, if not, f the following da less than the first this receipt. If a purchase on a pr	nd prer any pay ates: (a t preminy bala o rata b	mium payme yment receiv) the date of um under the nce due is no pasis.	ent have yed will this
POL	JCY.	Signed at(C	ity, State)				(Month-Day-	-Year)		
							(Agent)			

PREMIUM RATES FOR THE NONPARTICIPATING WHOLE LIFE PLAN

Description: Premium rates are based upon your age (nearest birthday) when the policy takes effect and do not change thereafter.

The rates included in the tables below were appropriate for the plans at the time they were prepared. The rates are subject to change without notice. You may confirm that the rates shown are the current rates by calling 1-800-523-5065.

If your policy will be at least \$10,000, Tables 1 & 3 are used.

If your policy will be <u>less than</u> \$10,000, Tables 1, 2, & 3 are used.

		BASI	C PREMIUM		BLE 1 R EACH \$1,00	0 OF INSUI	RANCE		
Age As of Your Nearest Birthday	Annual	Semi- Annual	Quarterly	ACP/ Monthly	Age As of Your Nearest Birthday	Annual	Semi- Annual	Quarterly	ACP/ Monthly
0-1	5.12	2.64	1.34	0.44	41	20.68	10.65	5.43	1.76
2	5.04	2.60	1.32	0.43	42	21.66	11.15	5.69	1.84
3	5.23	2.69	1.37	0.44	43	22.69	11.69	5.96	1.93
2 3 4 5	5.43	2.80	1.43	0.46	44	23.77	12.24	6.24	2.02
5	5.64	2.90	1.48	0.48	45	24.89	12.82	6.53	2.12
6	5.85	3.01	1.54	0.50	46	26.06	13.42	6.84	2.22
7	6.07	3.13	1.59	0.52	47	27.29	14.05	7.16	2.32
8	6.30	3.24	1.65	0.54	48	28.57	14.71	7.50	2.43
9	6.54	3.37	1.72	0.56	49	29.91	15.40	7.85	2.54
10	6.80	3.50	1.79	0.58	50	31.31	16.12	8.22	2.66
11	7.07	3.64	1.86	0.60	51	32.80	16.89	8.61	2.79
12	7.34	3.78	1.93	0.62	52	34.36	17.70	9.02	2.92
13	7.61	3.92	2.00	0.65	53	36.00	18.54	9.45	3.06
14	7.88	4.06	2.07	0.67	54	37.74	19.44	9.91	3.21
15	8.16	4.20	2.14	0.69	55	39.59	20.39	10.39	3.37
16	8.45	4.35	2.22	0.72	56	41.54	21.39	10.90	3.53
17	8.75	4.51	2.30	0.74	57	43.61	22.46	11.45	3.71
18	9.04	4.66	2.37	0.77	58	45.81	23.59	12.03	3.89
19	9.34	4.81	2.45	0.79	59	48.13	24.79	12.63	4.09
20	9.64	4.96	2.53	0.82	60	50.59	26.05	13.28	4.30
21	10.01	5.16	2.63	0.85	61	53.18	27.39	13.96	4.52
22	10.33	5.32	2.71	0.88	62	55.94	28.81	14.68	4.75
23	10.66	5.49	2.80	0.91	63	58.88	30.32	15.46	5.00
24	11.02	5.68	2.89	0.94	64	61.98	31.92	16.27	5.27
25	11.40	5.87	2.99	0.97	65	65.29	33.62	17.14	5.55
26	11.79	6.07	3.09	1.00	66	68.80	35.43	18.06	5.85
27	12.19	6.28	3.20	1.04	67	72.53	37.35	19.04	6.17
28	12.60	6.49	3.31	1.07	68	76.47	39.38	20.07	6.50
29	13.02	6.71	3.42	1.11	69	80.62	41.52	21.16	6.85
30	13.46	6.93	3.53	1.14	70	85.01	43.78	22.32	7.23
31	13.90	7.16	3.65	1.18	71	89.63	46.16	23.53	7.62
32	14.37	7.40	3.77	1.22	72	94.46	48.65	24.80	8.03
33	14.87	7.66	3.90	1.26	73	99.65	51.32	26.16	8.47
34	15.40	7.93	4.04	1.31	74	105.21	54.18	27.62	8.94
35	15.99	8.23	4.20	1.36	75	111.07	57.20	29.16	9.44
36	16.62	8.56	4.36	1.41					
37	17.31	8.91	4.54	1.47			1		
38	18.07	9.31	4.74	1.54			1		
39	18.88	9.72	4.96	1.60			1		
40	19.75	10.17	5.18	1.68					
		TABLE 2	<u> </u>				TABLE 3		
Annual Premium Surcharge If the amount of your Policy will be less than \$10,000: The annual							Policy Fee)	
			surcharge show			Annual		\$ 15.00	
		Δnn	ual Premium			Semi-Ann	ual	8.00	
If your Policy	will be:		urcharge			Quarterly ACP/Mon	thly	4.50 2.00	
\$ 9,000 - 9,99	99		\$ 1.00						
8,000 - 8,99			2.00		1				
7,000 - 7,99			3.00						
6,000 - 6,99			4.00						
Less than \$	6 000		5.00						

HOW TO CALCULATE YOUR PREMIUM FOR THE NONPARTICIPATING WHOLE LIFE PLAN

IF YOUR POLICY WILL BE AT LEAST \$10,000

All of the following premium modes (premium frequencies) are available to you if your policy will be at least \$10,000. Use Annual if you wish to pay your premiums annually, Semi-Annual if you wish to pay semi-annually, Quarterly if you wish to pay quarterly, or ACP/Monthly if you wish to pay monthly by Aetna's Automatic Check Plan.

TO CALCULATE your cost estimate use the appropriate age, policy amount, and selected premium mode.

EXAMPLE OUTLINED BELOW: AGE 40 - \$20,000 Policy - **Annual** Premium payments.

Extra LL Co Thi (Lb bllo W. 110L 10 20,000 Tolley Tallidal Floridal paymona	EXAMPLE	YOUR COST ESTIMATE
1. Enter the amount of insurance requested:	\$20,000	
2. Amount of insurance requested in #1 divided by 1,000 equals:	20	
3. From Table 1, enter premium rate which corresponds with your age and selected premium mode:	19.75	
4. Multiply #2 x #3:	395.00	
5. From Table 3, enter appropriate policy fee based on the selected premium mode:	15.00	
6. Add #4 + #5. This equals your periodic premium payment for the premium mode you selected:	\$410.00	

IF YOUR POLICY WILL BE LESS THAN \$10,000

If you wish to pay your premiums Annually, <u>omit</u> steps #6 + #7. If you wish to pay your premiums Semi-Annually, Quarterly, or ACP/Monthly, <u>include</u> steps #6 + #7.

TO CALCULATE your cost estimate use the appropriate age and policy amount.

EXAMPLE OUTLINED BELOW: AGE 40 - \$8,500 Policy - **Semi-Annual** Premium payments.

		EXAMPLE	YOUR COST ESTIMATE
1.	Enter the amount of insurance requested:	\$8,500	
2.	Amount of insurance requested in #1 divided by 1,000 equals:	8.5	
3.	From Table 1, enter Annual premium rate (regardless of premium mode selected) which corresponds with your age:	19.75	
4.	From Table 2, enter Annual Premium Surcharge based on the amount of your policy:	2.00	
5.	Add #3 + #4.	21.75	
	If you wish to pay your premiums Annually, omit steps #6 & #7.		
6.	If your premium is to be paid Semi-Annually, enter .5150 If your premium is to be paid Quarterly, enter .2625		
	If your premium is to be paid ACP/Monthly, enter .085	.5150	
7.	Multiply #5 x #6:	11.20	
8.	Multiply #2 x (#5 for Annual Payments) or (#7 for any other payment mode):	95.20	
9.	From Table 3, enter appropriate policy fee based on the selected premium mode:	8.00	
10.	Add #8 + #9. This equals your periodic premium payment for the premium mode selected.	\$103.20	