

Request for Conversion Form

Employer Name:

Certificate Number (If available):

Group Policy Number (If available):

I request that AFR Life Insurance Company convert my current Group coverage to an Individual Policy. The terms of this policy shall be in accordance with the conversion provision of the group insurance contract. It is agreed that the converted Individual Policy shall be deemed to be a continuation of the insurance under the Group Policy but shall be a new, separate, and independent contract and that all its terms and conditions shall be operative at and from its date of issue. All rights and interests of every kind in the converted amount of insurance under said Group Policy are hereby released and discharged.

Insured Information

Full Name:

Date of Birth:	Social Security Number:	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Address:

City:	State:	Zip:
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Phone Number:	Email Address:
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Owner Information

Name:

Relationship to Insured:

Date of Birth:	Social Security Number:	Phone Number:
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Address:

City:	State:	Zip:
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Beneficiary(ies)

PRIMARY BENEFICIARY

Name:

Relationship to Insured:

Date of Birth:	Social Security Number:	Phone Number:
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Address:

City:	State:	Zip:
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Name:

Relationship to Insured:

Date of Birth:	Social Security Number:	Phone Number:
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Address:

City:	State:	Zip:
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If the primary beneficiary(ies) is not living at the death of the Insured, we will pay the Contingent Beneficiary(ies).



CONTINGENT BENEFICIARY

Name:		Relationship to Insured:
Date of Birth:	Social Security Number:	Phone Number:
Address:		
City:	State:	Zip:
Name:		Relationship to Insured:
Date of Birth:	Social Security Number:	Phone Number:
Address:		
City:	State:	Zip:

Policy Information

Existing Coverage Amount:	Total Amount to Convert:
Effective Date of Existing Coverage:	<input type="checkbox"/> Tobacco User <input type="checkbox"/> Non-Tobacco User
Premium Mode-Bank Draft*: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annually	
Premium Amount:	

**For bank draft, the AFRL Bank Draft form must be completed.*

The Conditions Relating to Conversion

1. The Conversion Privilege may be exercised prior to the date coverage is reduced or ends as described in the Group Certificate as applicable.
2. The amount of insurance to be converted shall not be more than the amount of the Group insurance which ends.
3. The date of issue of any Individual Policy shall be the day following the last day of the period during which the Applicant has a right to convert the Group insurance as described in the Group Certificate.
4. Any Individual Policy shall take effect as of its date of issue, but only if: a) the Applicant has a right to convert his or her group insurance for the amount and plan of insurance applied for; and b) this application has been made and the first premium, according to AFR Life Insurance Company's published rates for the insurance applied for and the selected payment interval, is paid in full not later than the last day on which the Applicant has a right to convert his or her Group coverage, as applicable.

On my behalf, I declare and agree that all statements in this application are complete and true to the best of my knowledge.

Proposed Insured's Signature _____ Date: _____

Payor Signature (If Other than Proposed Insured) _____ Date: _____

Owner Signature (If Other than Proposed Insured) _____ Date: _____

Location Form Was Signed (City, State) _____