Notice of Conversion and/or Portability Rights

Important Notice regarding your coverage: You are receiving this notice as a result of experiencing a loss of coverage associated with The Hartford's Group policy provided by your employer. You have options to continue to be insured, which are explained below. The specific options available to you are based on the provisions as defined in the group policy. If you intend to apply for a policy, it is important that you submit a request for quote as soon as possible.

Life Conversion

The Life Conversion option provides the opportunity for you to obtain an individual life insurance policy that accumulates cash value and is offered at individual insurance rates. There are no mandatory age reductions and coverage can continue with premium payment until the Scheduled Maturity Date (standardly age 121) at which time the cash surrender value is paid to the insured. You will be eligible for Life Conversion if you experience a loss of coverage as the result of a change in your employment status, change in marital status, you or a dependent has experienced an age reduction or maximum age limit, you have retired or you have reached the end of an employer sponsored continuation provision. If coverage is ending because The Hartford Group Life policy is terminating or coverage for a class of employees is terminating, some restrictions may apply. If coverage is ending for any other reason, you can generally convert up to the full amount of your terminating coverage. Conversion is also available to your dependents if they had coverage under the group policy. You may have the option to obtain a one year term policy prior to the permanent life policy becoming effective. Please refer to The Hartford Group Life policy for information. **Premiums for a Life Conversion policy are substantially higher than the employer group policy rates.**

Frequently Asked Questions

Q: If I request a quote, how does The Hartford determine the amount of coverage to quote?
A: The quote is based on the amount of coverage you had under the group policy as well as any applicable policy provisions. The amount quoted is not a guarantee for your new coverage until The Hartford performs an eligibility review, validation of all information received, and medical underwriting, where applicable.

Q: What is my policy effective date?
A: When the application is approved and premium payment has been received, the effective date will be the day after your group benefits loss begins so that no gap in coverage would be experienced by you or your family.

Q: Can I be denied coverage?
A: Your request for coverage can be denied if you do not meet the timeline requirement as outlined above the signature line.

Q: If I start to work for a new employer and obtain coverage under that employer's group policy, will that group coverage impact any policy that I may purchase now?
A: If you obtain coverage under a new employer's group policy, your purchased policy(s) will remain in effect provided you continue to pay the required premiums.

Below is the information required to request a quote and the necessary forms to enroll. If you have questions about this information, your eligibility, or the status of any request you have submitted, please call a representative at **1-877-320-0484.**

The Hartford, Portability and Conversion Unit
P.O. Box 43786
Cleveland, OH 44143-0786
Fax 1-440-646-9339

E-mail request to: portabilityandconversions@selmanco.com with "Notice of Continuation of Coverage" in the subject line
https://info.selmanco.com/hartfordnocp

Employer Section: To be completed by the Employer or Employer Representative.

Employer: _____

Policy #: _____ Employee ID#: _____

Employee Name: _____

Last Day Worked (or date employee is no longer in an eligible class): _____

Date of Group Coverage Loss: _____ Loss of coverage reason: _____

Date of Hire: _____ Base annual salary: _____

Life Coverage: Please provide coverage amount in place at the time of loss of coverage

- Employee Supplemental Life: _____
- Spouse Supplemental Life: _____ • Child Supplemental Life: _____

The Hartford reserves the right to request additional information prior to accepting an application.

Employer Signature _____ **Print Name** _____

Employer Email Address _____ **Date** _____

Employee Section: To be completed by the Employee and submitted with the Employer Section via mail, fax, or e-mail, to initiate the quote and application for coverage options.

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I am interested in receiving a Quote/Application for the following:

☐ 12 month Term/Whole Life Conversion (12 month only available for groups sitused in NY & WV)

Please print the following information:

Name: _____

Date of Birth: _____ Social Security # **(indicate last 4 digits only):** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email: _____

I am interested in receiving information for the following persons:

☐ Myself ☐ My Spouse ☐ My Child(ren)

Please print the name(s), relationship, and date(s) of birth for each dependent who may be eligible for coverage. Include an additional sheet if necessary.

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

This notice is a part of a 3-step process to obtain coverage. For you to be eligible to start this process, your employer representative must have signed this notice no later than 90 days after the Group Coverage Loss Date. If your employer signs this notice prior to the Group Coverage Loss Date, we will treat the employer signature date as being the same as the Group Coverage Loss Date for purposes Steps 1 and 3.

Step 1: You have up to 31 days from the date your employer representative has signed this notice to submit this request (Employer AND Employee section) to The Hartford.
Step 2: Once we receive your completed request, we will send you an application and a quote. Depending on the mail, it may take two to three weeks for you to receive these. If you are concerned that you may not be able to obtain the application and quote in time to meet the deadlines outlined in Step 3, you may contact us by phone or email as outlined on this notice.
Step 3: If you choose to obtain coverage, you must submit the application and premium to us within 60 days from the date your employer representative has signed this notice.

_____ _____
Employee Signature (required) **Date**