Aetna™

Conversion of Group Term Life Insurance

Aetna Life Insurance Company

Life · Disability · Long Term Care

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

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.

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

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 reduced due to an age or retirement reduction rule) ..... _____
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 ..... _____

Signature (Employer Authorized Representative)	Date
Address	Telephone Number

HOME OFFICE USE ONLY

Name		
Group Control Number	SCD	
Regular Group Life	Control/Suffix	Claim/Account
Pooled Group Life	Control/Suffix	Claim/Account

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

I hereby apply for a policy of insurance upon my life in accordance with the provisions of Group Policy Number _____ insuring my life as an employee of _____

1. Proposed Insured (Print Name - First, Initial, Last)	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	Place of Birth	Telephone Number

2. Residence (Number, Street, City, County, State, Zip)	Social Security Number
	☐☐☐ ☐☐ ☐☐☐☐

3. a. Date employment terminated with above employer?	b. Occupation when employment terminated. Full Details.
Month _____ Day _____ Year _____	

c. What is your new occupation? Full Details.

d. Name of New Employer

4. a. Plan	b. Amount of Insurance (Must not exceed amount of term insurance when employment terminated.)
Whole Life Insurance	$

c. Premium Payable	d. Make Automatic Premium Loan Provision operative, if available.
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ ACP/Monthly* *Complete Deduction Form	☐ Yes ☐ No

e. Has any premium been paid and conditional receipt given on Form 265?

☐ Yes
☐ No

If "Yes," amount $_____

If "Yes," the terms of the receipt are hereby agreed to. If "No," no insurance will be effective until the entire first premium for the policy is paid within 30 days from the date of this application during the lifetime of the proposed insured, nor until the term insurance under the Group Policy ends (if under the terms of the Group Policy such insurance extends beyond the date of this application).

5. Premium Notices to be sent

☐ **Insured at Residence** ☐ **Other** _____

6. a. **Beneficiary** (NAME AND RELATIONSHIP TO PROPOSED INSURED) (NAME AND RELATIONSHIP TO PROPOSED INSURED)

Primary _____ Contingent _____

Unless otherwise requested herein, payment is to be made to primary beneficiaries who survive the Insured, equally, or if none survives, to contingent beneficiaries who survive, equally, or if none survives, to Insured's estate.

b. Policyowner (Unless otherwise requested, Proposed Insured is to be Policyowner.)

7. Additional Information (Refer to specific question number.)

IT IS MUTUALLY AGREED THAT: (1) the statements and answers made herein are complete and true to the best of my knowledge and belief; (2) issuance of the policy applied for shall be exchanged for all privileges and benefits with respect to the full amount of term insurance on my life under the Group Policy; (3) no person other than an officer of Aetna can make, modify, or discharge a contract or waive any of Aetna's rights or requirements.

Signed at _____ **on** _____

(City, State) **(Month-Day-Year)**

X _____ X _____

Witness Signature - **May Not** be a Named Beneficiary **Signature of Proposed Insured**

X _____ X _____

Print Witness Name **Signature of Applicant (if other than Proposed Insured)**

FOR HOME OFFICE USE ONLY
RECEIVED _____
INDIVIDUAL POLICY TO BE DATED _____

GR-89008-APP GR-66109 (5-02) A-WH

DO NOT COMPLETE OR DETACH UNLESS ADVANCE PAYMENT IS MADE OF AT LEAST THE PREMIUM FOR ONE MONTH

CONDITIONAL RECEIPT

Received $_____ in connection with an Application to Aetna Life Insurance Company for Conversion of Group Term Life Insurance on the life of _____

Notice: If you do not hear from the Company concerning the proposed insurance within 60 days, notify Aetna at its Home Office at Hartford, Connecticut. READ YOUR POLICY.

IT IS MUTUALLY AGREED THAT: (1) no insurance will be effective unless this application and premium payment have been made in accordance with the terms of the Group Policy referred to in the application, if not, any payment received will be refunded; (2) the effective date of insurance applied for will be the LATER of the following dates: (a) the date of this receipt, or (b) the date the Group Term Insurance ends; and (3) if the payment is less than the first premium under the policy, the balance of that premium may be paid within 60 days from the date of this receipt. If any balance due is not paid, any insurance provided will continue only for the period which the payment will purchase on a pro rata basis.

Signed at _____ on _____

(City, State) (Month-Day-Year)

_____

(Agent)

Form 265 GR-66109 (5-02) A-WH

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 less than $10,000, Tables 1, 2, & 3 are used.

TABLE 1
BASIC PREMIUM RATES FOR EACH $1,000 OF INSURANCE

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
4	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					
38	18.07	9.31	4.74	1.54					
39	18.88	9.72	4.96	1.60					
40	19.75	10.17	5.18	1.68					

TABLE 2
Annual Premium Surcharge

If the amount of your Policy will be less than $10,000: The annual rates shown in Table 1 are added to the surcharge shown below:

If your Policy will be:	Annual Premium Surcharge
$ 9,000 - 9,999	$ 1.00
8,000 - 8,999	2.00
7,000 - 7,999	3.00
6,000 - 6,999	4.00
Less than $6,000	5.00

TABLE 3
Policy Fee

Annual	$ 15.00
Semi-Annual	8.00
Quarterly	4.50
ACP/Monthly	2.00

NOTE: To determine your premium, see page entitled "HOW TO CALCULATE YOUR PREMIUM."

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.

		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 <u>LESS THAN</u> $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	