



**NOTICE OF RIGHT OF CONVERSION OF INSURANCE
FOR ELIGIBLE TERMINATED EMPLOYEES AND DEPENDENTS, IF APPLICABLE**

You are hereby notified that under the terms of the group policy, you are entitled to convert your Group Term Life Insurance without medical examination. You may convert to an individual insurance policy of any form currently issued by Central Reserve Life, except Term Insurance. You may also be eligible to convert your medical insurance (not available in South Carolina).

IF YOU DESIRE TO CONVERT YOUR INSURANCE, YOU MUST ACT PROMPTLY BY MAKING APPLICATION AND PAYING THE FIRST PREMIUM TO CENTRAL RESERVE LIFE WITHIN THIRTY-ONE DAYS FOLLOWING THE DATE OF TERMINATION OF EMPLOYMENT.

You may receive application and rates by completing and mailing the bottom of this form to Central Reserve Life.

IMPORTANT NOTICE

In lieu of conversion of your Group Life Coverage, you may want to consider making direct application to Central Reserve Life for an individual life insurance policy. In this way, you may be eligible for waiver of premium, accidental death benefits and special discounts if you are a non-smoker or a "preferred risk." In addition, the maximum amount of insurance available to you would not be restricted to the amount of Group Life Insurance being terminated. While direct application may require a physical examination, the examination is at no cost to you. In any event, you will still be eligible for conversion if your direct application cannot be approved.

IF YOU WISH TO CONVERT YOUR GROUP INSURANCE, PLEASE FILL IN THE INFORMATION REQUESTED BELOW AND FORWARD IT TO THE LIFE OPERATIONS DEPARTMENT AT CENTRAL RESERVE LIFE, 17800 ROYALTON ROAD, STRONGSVILLE, OHIO 44136-5197

PLEASE PRINT

Account Number _____

Employer _____

Termination Date _____

I would like information to convert my:

- 1. Employee Group Term Life Insurance
- 2. Dependent Spouse Group Term Life Insurance
- 3. Medical Insurance (Not available in South Carolina)
 - Family Coverage
 - Single Coverage

Employee Name _____

Dependent Spouse Name _____

Address _____

Address _____

Home Phone _____

Home Phone _____

Birth Date _____

Birth Date _____

Number of Dependent Children to be covered for medical insurance: _____

Prompt completion of the above information will enable us to provide you with an application form and other details pertaining to your conversion. THIS FORM DOES NOT CONSTITUTE AN APPLICATION.