



**APPLICATION FOR CONVERSION OF
GROUP LONG TERM DISABILITY INSURANCE**

How To Apply: This form completed by the applicant, together with a check for the first quarterly premium and a one time initial non-refundable application fee of \$25.00 must be **received** within 31 days after termination of group coverage at:

AETNA LIFE INSURANCE COMPANY, C/O JHA CONVERSION SERVICE CENTER, PO. BOX 7146, PORTLAND, ME 04112

THIS SECTION IS TO BE COMPLETED BY THE APPLICANT

1. Name (Last, First, Middle Initial)		2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Home Address (Street, City, State, Zip)		4. Date of Birth:	
5. Social Security Number		6. Telephone Number:	
7. Are you on a leave of absence? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Are you disabled under the terms of the group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Are you currently unable to work due to a mental or physical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		10. Within 31 days of termination, have you or will you become insured for long term disability insurance under another group insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY OR WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE AN INSURANCE COMPANY, FILES A STATEMENT CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

THE STATEMENTS ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND I AGREE THAT THEY SHALL FORM A PART OF THE CONTRACT OF INSURANCE APPLIED FOR.

Signature of Applicant

Date

Upon approval of this application, a certificate of coverage will be sent directly to you at the address provided.

THIS SECTION IS TO BE COMPLETED BY THE EMPLOYER

1. Employer (Firm Name and Division)		2. Employer's Address (Street, City, State, Zip)	
3. Group LTD Plan Number		4. Group LTD Plan Maximum Benefit:	5. Has the group plan terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the applicant on a leave of absence? <input type="checkbox"/> Yes <input type="checkbox"/> No		7. Has the applicant retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Are premiums paid to date for the applicant under the group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Applicant's occupation at time of termination:		10. Has the group plan been amended to exclude the class of employees to which the applicant belongs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Applicant's date of hire:	12. Date applicant terminated employment:		13. Date applicant was last actively at work:
14. Reason for termination:		15. Applicant's monthly earnings at time of termination:	
16. Was the applicant covered under your present group plan or under a combination of your present and prior group plan for at least 12 consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No * If yes, applicant's effective date of coverage: _____			
* IF NO, THIS INDIVIDUAL IS NOT ELIGIBLE FOR LTD CONVERSION COVERAGE			
17. When was the applicant notified of the Conversion Privilege:			

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Signature of Employer's Representative

Date