Reset

**RELIANCE STANDARD LIFE INSURANCE COMPANY**

**APPLICATION FOR CONVERSION TO INDIVIDUAL ACCIDENT POLICY**

This form must be completed in full and submitted to Reliance Standard Life Insurance Company within 31 days following date of termination of insurance.

SEND TO: Reliance Standard Life Insurance Company
Attention: Annuity New Business
2001 Market Street, Suite 1500
Philadelphia, Pennsylvania 19103-7090

VERIFICATION OF INSURED PERSON'S ELIGIBILITY FOR CONVERSION OF GROUP VOLUNTARY ACCIDENT INSURANCE

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**To be Completed by Policyholder**

Date _____

1. Insured Person's full name _____
(Please Print)

2. Insured Dependent Spouse's full name, if applicable _____
(Please Print)
Insured Dependent Children's full names, if applicable _____
_____
(Please Print)

3. Group Policy No. _____

4. Name of Group Policyholder _____

5. Federal Employer Identification No. _____ Branch or Location _____
(if different from 4)

6. Date of Termination of Insurance _____
Reason _____

7. If Employment Termination, Date Person last worked _____

8. If (6) & (7) differ, please explain _____

9. Amount of Group Insurance in force on this individual under the Group Policy on date of termination of insurance: $ _____

10. Amount of Group Insurance in force on Dependents under the Group Policy on date of termination of insurance, if applicable: Spouse $_____ Child(ren) $_____

11. Verified by _____

I have reviewed the information set forth, and certify that it is true and correct.
(Signature and title of authorized individual)

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**APPLICATION FOR CONVERSION**
**To Be Completed By Insured**

Application is hereby made for conversion to an individual accident policy. I desire to convert $ _____ of my accident insurance to an individual policy. I desire to convert $ _____ of insurance for my dependent spouse and $ _____ of insurance for my dependent children to an individual policy, if applicable. Enclosed is my check for the annual premium, made out to Reliance Standard Life Insurance Company, in the amount of $ _____ .

**GROUP ACCIDENT POLICY CONVERSION RATES**
**ALL RATES ARE ANNUAL PER $1,000.00 OF COVERAGE**

| Age | Rate |
|---|---|
| 0-39 | $1.30 |
| 40-49 | $1.45 |
| 50-59 | $1.65 |
| 60-64 | $2.25 |
| 65-69 | $3.00 |
| 70 + | $6.00 |

RATING EXAMPLE: If a 52 year old insured wishes to convert $50,000.00 of coverage, the annual cost would be $82.50 ($1.65 X 50). NOTE: Conversion rates for your spouse and each dependent should be calculated separately based on their amount of insurance, if applicable.

Beneficiary Designation

| Name | Relationship | Social Security Number | % of Proceeds |
|---|---|---|---|
| Primary: | | | |
| Contingent: | | | |

_____
(please print)

_____

_____
(please print)

_____

I have read the statements set forth and certify that they are accurate and complete. I understand that this insurance will be issued in reliance upon such statements.

Address _____
(Street) (City, State, Zip)

Date of Birth _____ Social Security Number _____

Insured Dependent Spouse's: date of birth and Social Security Number, if applicable:

_____

Insured Dependent Children's Names, Dates of Birth and Social Security Numbers, if applicable:

_____

_____

_____

_____ _____
Proposed Insured's Signature Date Signed

LRS-5236-0393