

**REQUEST FOR LIFE INSURANCE CONVERSION QUOTE**  
**Madison National Life Insurance Company, Inc.**

Madison National Life  
Insurance Company, Inc.  
P.O. Box 5008  
Madison, WI 53705  
608-238-2691 • 800-356-9601

“**RIGHT TO CONVERT**” as indicated in your Certificate of Insurance Page 6, Part V, paragraph 3:

“the insured person applies and pays the first premium for such individual life policy within 31 days following termination or reduction of life insurance benefit under the policy. Such individual life policy will become effective on the first day following the end of such 31 day period.”

Premium for such individual life policy will be based on:

- a. the Company’s usual rate for the amount and type of individual life policy;
- b. the insured person’s class of risk; and
- c. the insured person’s attained age.

**EMPLOYER’S STATEMENT**

Employer’s Name: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Complete the following information about your employee and his/her coverage:

Effective date of coverage under group policy: \_\_\_\_\_ Date of Retirement/Termination: \_\_\_\_\_

Is insurance extended beyond Date of Retirement/Termination?  No  Yes; reason for extension: \_\_\_\_\_

Date Insurance Coverage will End (including extension if applicable): \_\_\_\_\_

Amount of Coverage		
\$ _____	\$ _____	\$ _____
BASIC LIFE COVERAGE	SUPPLEMETNAL LIFE COVERAGE	DEPENDENT COVERAGE

\*\*Date Conversion Information Was Given To Employee: \_\_\_\_\_

Name and Title of individual completing this form (please print): \_\_\_\_\_

Telephone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please have employee complete the following information.

**EMPLOYEE’S STATEMENT**

Name (print) \_\_\_\_\_ Telephone: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male:  Female:  Amount of coverage requested: \_\_\_\_\_  
(This amount cannot exceed the current amounts as listed above)

**FOR DEPENDENT COVERAGE:** If you have dependent coverage that you would like to convert please attach an extra page listing your dependent’s name, date of birth, gender, and amount of coverage you would like quoted. If your dependent has a different mailing address than please include that as well.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE NOTE:** This is not an application for conversion. This is a request to receive premium information. In order to convert your coverage you must complete an application and pay the first year’s premium within 31 days of your insurance coverage ending. Once you have received premium information Madison National Life will provide an application upon your request. If you are not interested in receiving a quote please disregard this notice.