Madison National Life

Insurance Company, Inc.

P.O. BOX 5008, MADISON, WI 53705
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

REQUEST FOR LIFE INSURANCE CONVERSION QUOTE

This is not an application for conversion. This is a request to receive premium information. To convert your coverage you must complete an application and pay the first year's premium within 31 days of your insurance coverage termination. 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.

EMPLOYER'S STATEMENT

Employer's name:_____ Group/Policy number:_____

Employer's address:_____

Street City State Zip Code

Employee's date of hire:_____ Employee's occupation:_____

Last date employee actually worked:_____ Average number of hours employee worked/week:_____

Employee's annual salary:_____ Employee's effective date of coverage under the group policy: _____

Date of Employee's Retirement / Termination from employment : _____

Was the Employee's insurance extended beyond the date of retirement / termination? ☐ No ☐ Yes If yes, please indicate the reason for the extension: _____

_____

_____

Date insurance coverage ended / will end (including extension if applicable): _____

Amount of Coverage

Basic Group Term Life: **Supplemental Group Term Life:** **Dependent Group Term Life:**

$_____ $_____ $_____

Date conversion information was given to the employee: _____

Name and title of individual completing this form (please print):_____

Telephone number:_____ Fax number:_____

Signature:_____ Date:_____

EMPLOYEE'S STATEMENT

This is not an application for conversion. This is a request to receive premium information. To convert your coverage you must complete an application and pay the first year's premium within 31 days of your insurance coverage termination. 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.

Name (print): _____ Telephone number: _____

Address: _____

City: _____ State: _____ Zip: _____ Email address: _____

Date of birth: _____ ☐ Male ☐ Female

Amount of coverage requested: (This amount cannot exceed the current amounts as listed above): $_____

If you do not have dependents, or are not interested in converting coverage for your dependents, you do not need to complete the following questions.

Amount of coverage requested for dependents: (This amount cannot exceed the current amounts as listed above): $_____

Dependent coverage: If you have dependent coverage that you would like to convert please complete the information below. If you have more than four dependents you can provide the necessary information on a separate page.

Dependent 1

Name:_____Gender:_____

Date of birth: _____Amount of Coverage:_____

Complete address (if different than your own):_____

_____

Dependent 2

Name:_____Gender:_____

Date of birth: _____Amount of Coverage:_____

Complete address (if different than your own):_____

_____

Dependent 3

Name:_____Gender:_____

Date of birth: _____Amount of Coverage:_____

Complete address (if different than your own):_____

_____

Dependent 4

Name:_____Gender:_____

Date of birth: _____Amount of Coverage:_____

Complete address (if different than your own):_____

_____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature_____ **Date**_____

Fraud Warnings

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature: _____ Date: _____