

Business Men's Assurance Company
Request for Conversion Information
Life or LTD Group Insurance

Please provide information about converting from the insurance coverage described below.

Group Life Insurance

Group LTD Insurance

1. Insured through Policy Number: _____

Name of Employer
or Association: _____

2. Name of Insured: _____ Sex: Male Female

3. Insured's Date of Birth: _____ Insured's Social Security No: _____

EMPLOYER MUST COMPLETE THIS SECTION

4. If Insured's employer or association group coverage has terminated:
Date coverage terminated: _____ Reason coverage terminated: _____

5. Insured has been covered under the employer or association group policy since: _____
(Effective Date)

Complete the following questions for Life Conversions:

6. INSURED:

Amount of life insurance Insured had on the date prior to termination of coverage: \$ _____

DEPENDENTS:

Amount of life insurance dependent spouse had on the date prior to termination of coverage: \$ _____

Amount of life insurance dependent children had on the date prior to termination of coverage: \$ _____

Spouse Name: _____ Sex: Male Female Date of Birth: _____

Child Name: _____ Sex: Male Female Date of Birth: _____

Child Name: _____ Sex: Male Female Date of Birth: _____

Child Name: _____ Sex: Male Female Date of Birth: _____

Date coverage terminated: _____

Reason coverage terminated: _____

Complete the following questions for LTD Conversions:

7. Insured's monthly earnings on the date prior to termination of coverage: _____

Present Mailing Address:

(Street)

(City)

(State)

(Zip)

(Date)

(Signature)

Please Mail to:

BUSINESS MEN'S ASSURANCE COMPANY
BMA Tower
P. O. Box 419269
Kansas City, Missouri 64141

THIS FORM MUST BE RECEIVED BY BMA WITHIN 31 DAYS AFTER TERMINATION UNDER THE GROUP EMPLOYER OR ASSOCIATION COVERAGE.