

REQUEST FOR GROUP LIFE CONVERSION INFORMATION

Employee: _____ Phone #: _____

Complete Address: _____

Employer: _____

Your Group Insurance coverage terminated: _____
(the last day you worked full-time)

Your Group Life Insurance contained a "Conversion Privilege" provision for yourself and your dependent(s) (if covered). If you wish information on your conversion option, please complete and return this form to United Heritage Life. Your conversion application and initial premium must be submitted within **31 days** following the date your full-time employment terminated.

	Employee	Spouse	Child	Child	Child
Name					
Date of Birth					
Gender	M / F	M / F	M / F	M / F	M / F
Have you smoked one or more cigarettes in last 12 months?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Have you used tobacco in any form in last 12 months?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Amount of Insurance					

60-09(Rev 8/97)

Mail to:

**UNITED
HERITAGE**

P.O. Box 7777
Meridian, ID 83680-7777