

**GROUP LIFE CONVERSION APPLICATION**  
**Reliance Standard Life Insurance Company**

This form is to be used only when an eligible person desires to convert his Group Life insurance to an Individual policy. This form must be completed in full and submitted to the Company within 90 days following the effective date of termination of insurance. The top portion of this form is to be completed by the policyholder, the lower portion by the applicant. You may wish to refer to your policy's Schedule of Benefits page to complete some of the questions on this application.  
Questions? Call Customer Care at 1-800-351-7500.

**When all areas are complete, mail to: Insurance Services**  
**Division of Protective Life Insurance Company**  
**Post Office Box 12687**  
**Birmingham, AL 35202-6687**  
**Fax: (205) 268-3402**  
**Email: ladphs@protective.com**

**TO BE COMPLETED BY POLICYHOLDER**

Name and Address of Group Policyholder and, if applicable, Division Name: \_\_\_\_\_  
Policy No.: \_\_\_\_\_ Policy Eff. Date: \_\_\_\_\_  
Insured's Full Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Annual Salary/Earnings: \_\_\_\_\_ \$ \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Date Employment Began: \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Date Last Worked: \_\_\_\_\_  
Scheduled Work Hours: \_\_\_\_\_/week Insured's Premium Paid To: \_\_\_\_\_  
Insured's Effective Date: \_\_\_\_\_ Insurance Class: \_\_\_\_\_ Insurance Amount: Basic \$ \_\_\_\_\_ Supp \$ \_\_\_\_\_  
Reason Insured Stopped Work (specify): \_\_\_\_\_ Dependent Amt: \$ \_\_\_\_\_  
Conversion Rights Exercised Due To (check applicable response):  
\_\_\_\_ (1) Employee Terminated Employment On: \_\_\_\_\_  
\_\_\_\_ (2) Group Policy Terminated On: \_\_\_\_\_  
\_\_\_\_ (3) Disability of the Insured On: \_\_\_\_\_ Has A Waiver of Premium Claim Been Submitted to RSL? Yes \_\_\_ No \_\_\_  
If No, Please Explain: \_\_\_\_\_  
\_\_\_\_ (4) Other, Please Explain: \_\_\_\_\_  
I have reviewed the information set forth, and represent that to the best of my knowledge and belief it is true and correct.

\_\_\_\_\_  
Signature Of Policyholder's Authorized Representative Title Date Signed  
\_\_\_\_\_  
Phone Number of Representative Federal Employer Identification Number

**TO BE COMPLETED BY APPLICANT**

I would like to convert \$ \_\_\_\_\_ of my group life insurance coverage that was in-force prior to the termination date.  
Desired Mode of Premium Payment \_\_\_\_\_ Quarterly \_\_\_\_\_ Semi-Annually \_\_\_\_\_ Annually

**Beneficiary Designation**

Upon the death of the insured, the proceeds of the policy to which this application is attached shall be paid as follows:  
*Primary Beneficiary(s)*  
Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Percentage \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Percentage \_\_\_\_\_  
*Contingent Beneficiary(s)*  
Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Percentage \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Percentage \_\_\_\_\_  
If more than one primary beneficiary is named and no percentage is indicated, payment will be in equal shares to the surviving primary beneficiary(s). If there are no surviving primary beneficiary(s), the proceeds will be paid to the contingent beneficiary(s). If more than one contingent beneficiary is named and no percentage is indicated, payment will be in equal shares to the surviving contingent beneficiary(s). If there are no surviving contingent beneficiary(s), the proceeds will be paid to the executors, administrators, or assigns of the owner.

Applicant's Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

I have reviewed the information set forth above and represent that to the best of my knowledge and belief it is true and correct  
Signature \_\_\_\_\_ Date Signed \_\_\_\_\_