Life Conversion Coverage

Life Goes on with Group Conversion

Your group life insurance has been valuable protection for you and your family. Now that it will be terminated, you may wish to convert this important coverage to an individual policy. This information has been prepared to help you take advantage of your right to continue your protection.

About Life Conversion Coverage

Life Conversion Coverage is individual permanent life insurance issued without evidence of insurability.

Life Conversion Coverage can be obtained when your life insurance under the group policy ends. Your group certificate will describe when conversion coverage is available to you, and will show the amount of coverage you can convert.

Conversion coverage will be issued without evidence of good health, provided:
(a) you complete the attached application,
(b) you enclose a check or money order for the first premium payment and
(c) these items are forwarded to us within 31 days after your group insurance ends.

Your conversion policy will be effective on the 31st day after your group insurance ends. During this 31-day period, you remain covered under the continued coverage provision of your group certificate.

You may apply for an amount that is not more than the amount of your current group insurance coverage (this is your maximum). You may elect coverage in $1,000 increments up to your maximum.

Premium rates for the individual whole life policy which is available are shown in the table that follows. This policy provides a level death benefit and premiums are payable until the policy anniversary following your 95th birthday. If premium payments are discontinued, you may:
(a) receive any existing cash value or
(b) use the cash value to purchase extended term insurance or a reduced amount of paid-up life insurance.

For additional information or premium rates on conversion coverage, please write or call us at:

Attn: Group Policy Services, Group Conversion
Companion Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: 1-800-826-8054

To Apply for Life Conversion Coverage

In order to apply for life conversion coverage, you must do the following:

1) Complete the Life Conversion Application that follows. Write clearly and do not erase – any corrections should be crossed out and initialed by you. Answer each question fully – do not use dashes or ditto marks.
2) Make sure the section entitled "Information to be Completed by the Personnel Office" is completed by the employer or administrator of the group policy.
3) Attach your check or money order payable to Companion Life Insurance Company for the first annual or semiannual premium payment.
4) Send your premium payment and completed application to the above address within 31 days after your group insurance ends.

Privacy Notice: *When Companion Life Insurance Company evaluates an application for life conversion coverage, only the information on the application is reviewed. This information, and other information we may later collect to administer coverage, may sometimes be disclosed without your express authorization. We have a procedure which allows you to review and amend any information we collect about you – other than information relating to a claim, lawsuit or criminal proceeding. If you would like to know more about our information practices, please write us at the address shown above.*

Calculating The Premium

The premium amounts in the table below are per $1,000 of coverage. Calculate your annual and/or semiannual premium in the calculation worksheet, following the steps and example below.

To calculate annual and semiannual premium:

1) Divide your desired death benefit amount by 1,000.
2) Locate your age group and gender on the table below to identify the premium rate per thousand.
3) Multiply #1 by #2 above.
4) Add $36 for the annual policy fee to obtain the **annual premium** for the coverage.
5) Multiply the annual premium by .52 to obtain the **semiannual premium** for the coverage.

Issue Age	Male	Female
0-4	$6.80	$6.10
5-9	$7.70	$6.90
10-14	$8.80	$7.80
15-19	$10.00	$9.00
20-24	$17.00	$12.50
25-29	$21.00	$15.00
30-34	$25.00	$17.50
35-39	$30.00	$20.50
40-44	$35.00	$24.00
45-49	$41.00	$30.00
50-54	$46.00	$33.00
55-59	$58.00	$40.00
60-64	$80.00	$51.00
65-69	$111.00	$72.00
70-74	$154.00	$108.00
75-79	$196.00	$149.00
80-84	$238.00	$198.00
85	$304.00	$255.00

Example (Assumes a 50-year-old male with current group life coverage of $20,000.)

20	x	$46.00	=	$920.00	+	$36	=	$956.00
Desired coverage amount/$1,000		Premium rate per thousand		Premium for coverage		Annual policy fee		**Total annual premium**

$956.00 x .52	=	$497.12
Total annual premium		**Total semiannual premium**

Calculation Worksheet

_____	x	_____	=	_____	+	$36	=	$ _____
Desired coverage amount/$1,000		Premium rate per thousand		Premium for coverage		Annual policy fee		**Total annual premium**

_____ x .52	=	_____
Total annual premium		**Total semiannual premium**

Companion Life Insurance Company
A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

Conversion Application

This application must be completed and mailed within 31 days after your group insurance ends. Mail the conversion to: Attn: Group Policy Services, Group Conversion, Companion Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

Life Insurance Section

1 Applicant's Name (First, Middle, Last)

_____

2 Social Security Number

_____

3 Male ☐ Female ☐

4 Age _____ **5** Date of Birth _____
Mo. Day Yr.

6 Residence (Number, Street, City, State, ZIP)

_____

_____

7 Home Phone Number (_____)_____

8 Plan of Insurance_____

9 Amount of Insurance $_____
(Show amount in thousands, not greater than the amount you are entitled to convert.)

10 Mode of Premium Payments

☐ Annually ☐ Semiannually

11 Amount Paid with Application

$_____

12 Beneficiary (Give full name and relationship to applicant)

Primary Beneficiary Designation

Last Name	First Name	SSN	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary Address, City, State, ZIP	Telephone Number	Benefit Percent (%)
						Percentage Total:	

Secondary Beneficiary Designation

Last Name	First Name	SSN	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary Address, City, State, ZIP	Telephone Number	Benefit Percent (%)
						Percentage Total:	

Payment will be shared equally by all primary beneficiaries who survive you; if none, it will be shared equally by all contingent beneficiaries who survive you. Unless otherwise stated, you have the right to change the beneficiary.

Group Information Section

1 Group Policyholder _____ Group Policy No. _____

2 I have been insured under the above Group Policy as: ☐ An employee or member ☐ A dependent

3 I became insured under the Group Policy: _____ Month _____ Day _____ Year

4 My group insurance terminated: _____ Month _____ Day _____ Year

5 Was termination due to disability? ☐ Yes ☐ No
(If "Yes," give date and cause of disability.) _____

Life Agreements Section

I am applying to Companion Life Insurance Company for the life conversion coverage shown above. I agree Companion will not be under any obligation or liability under this application unless:

(1) I have the right to convert the insurance shown above.
(2) The application is made within 31 days after my group insurance ends.

Date _____ , _____ State signed in _____

_____
Applicant's Signature

Information to be completed by the personnel office

Group Policyholder _____

Policy No. _____ Phone (_____) _____

Address (Number, Street, City, State, ZIP) _____

Applicant's Name _____

Certificate No. _____

1 The Applicant was insured under the above Group Policy as: ☐ An employee or member ☐ A dependent

2 For what amount of coverage was the Applicant insured? $_____

3 What is the Applicant's date of birth? _____ Month _____ Day _____ Year

4 When did the Applicant become insured under the Group Policy? _____ Month _____ Day _____ Year

5 The Applicant's coverage was: ☐ terminated on _____ Month _____ Day _____ Year
☐ reduced by $_____ on _____ Month _____ Day _____ Year

Because of _____

Completed by _____ Signature (Employer or Administrator)

Title _____ Date _____ , _____