GROUP HEALTH CONVERSION FORM

Company Name: ____ Policy # ___________________________

Name of Applicant: ____ Certifcate #_________________________

Termination Date: ____
dd/mm/yyyy

Reason for Termination:____

Do you wish to have coverage for you and your dependents? ☐ No ☐ Yes

Deductible: ☐ $500 ☐ $1,000 ☐ $2,000

Do you wish to have Dental and Vision coverage? ☐ No ☐ Yes

Name of Advisor: ____

IF YOU DO NOT HAVE AN ADVISOR ONE WILL BE ASSIGNED TO YOU.

Address of Applicant:____
Street City/Parish Country

Email Address: _____________________________________

Telephone Numbers: Cell: ______________________________ Home: ______________________________

Signature of Applicant:_____________________________________ Date: _________________________________

Signature of Administrator:___________________________________

SUBJECT TO THE INDIVIDUAL HEALTH CONVERSION GUIDELINES

FOR OFFICIAL USE ONLY

Date Group Policy Terminated ____

Date Conversion Option Expires _______________________________________

Major Medical maximum: ____

Verified By ____ Date ___________________________

GI40047– 8th August 2022 - B'dos