

Preliminary Application for Life Conversion

CBA Benefit Services
73 East Wilson Bridge Road, Suite B-6
Worthington, OH 43085
1-866-880-0068



The conversion privilege contained in the Group Policy and described in your certificate provides that you may convert your Group Insurance to an individual whole life policy by applying for such conversion within 31 days from the date your coverage terminates. For further information complete this form immediately and forward to American United Life Insurance Company[®] at the above address.

TO BE COMPLETED BY APPLICANT

Name _____ Sex _____ Date of Birth _____
(Please Print)

Address _____
Street City State Zip

Social Security Number _____ Home Phone Number (____) _____

Have you smoked cigarettes, cigars, used a pipe, smokeless tobacco, or chewed tobacco in the past 12 months? Yes No

Dependents applying for an individual whole life policy:

<i>Name</i>	<i>Relationship</i>	<i>Date of Birth</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any of the above-named dependents smoked cigarettes, cigars, used a pipe, smokeless tobacco, or chewed tobacco in the past 12 months? Yes No

If yes, please list them by name _____

TO BE COMPLETED BY THE GROUP PLAN ADMINISTRATOR

Group Policy/Participating Unit Number _____

Name of Group Policyholder/Participating Unit _____

Original effective date of group coverage for applicant _____

Date group coverage terminates for the applicant _____

Circle the reason for the termination of this applicant's coverage:

- 1. Termination of Group Policy
- 2. Termination of employment
- 3. Reduction of Life Insurance Amount
- 4. Divorce from primary insured
- 5. Death of primary insured
- 6. Attainment of limiting age, full time employment or marriage by a dependent child
- 7. Other _____

Amount of Life Insurance eligible for conversion under Group Plan \$ _____ Basic
\$ _____ Voluntary/Supplemental \$ _____ Dependent

It is understood that should the applicant return to work for you, and if this conversion policy is issued and remains in force at such time of resumption of employment, Evidence of Insurability will be required of the applicant before he can again become insured for insurance under the Group Policy.

Signed by: _____ Telephone # (____) _____
(title) (Date)