



INTERNAL USE ONLY:

Check Enclosed: Yes No

Amt: \$ _____

Attachments: _____ Initials: _____

Request for Conversion Form

Current Group Policy Information for Conversion

Group Association or Employer _____

Certificate Number: _____ if applicable
Group Policy Number: _____ if applicable

I hereby request that 5Star Life Insurance Company convert my current group coverage to an individual policy. The terms of this policy shall be in accordance with the conversion provision of the group insurance contract. It is agreed that the converted individual policy shall be deemed to be a continuation of the insurance under the Group Policy, but shall be a new, separate, and independent contract and that all its terms and conditions shall be operative at and from its date of issue. All rights and interests of every kind in the converted amount of insurance under said Group Policy are hereby released and discharged.

Insured Information

Insured's Full Name (First, Middle, Last) _____

Insured's SSN _____ DOB (MM/DD/YYYY) _____ Male Female

Home Address:

Street Line 1 _____

Street Line 2 _____

City _____ State _____ Zip _____

Daytime Contact Phone Number _____

Email address: _____

Owner (if other than applicant)

Social Security Number: _____

Name: _____

Address: _____

City, State, Zip: _____

Relationship to Applicant: _____

Phone No. _____

Payor

Owner Applicant Other (Complete all info below)

Social Security Number: _____

Name: _____

Address: _____

City, State, Zip _____

Phone No. _____

Policy Information

Payment Mode/

of Months Payment:
(Please choose one.)

MonthlyBank 1
Draft

Quarterly 3

Semi-Annually 6

Annually 12

Existing Coverage Amount: _____ Tobacco user Non-tobacco user

Total Amount to Convert: _____

Effective Date of Existing Coverage: _____

	Premium	# of Months Payment	Total Premium Due
\$	_____	x _____	\$ _____

Continued on back.

Underwritten by 5Star Life Insurance Company

Admin. Office: 909 N. Washington Street, Alexandria, VA 22314 • 1-800-776-2322 • www.afba.com

Beneficiary(ies)

I designate my beneficiary(ies) to receive benefits, in order of class, as indicated below. Check here if you would like an additional beneficiary form sent to you.

Primary _____
Name Address Relationship SSN DOB

Secondary _____
Name Address Relationship SSN DOB

Conditions Relating to this Conversion Form

1. The Conversion Privilege may be exercised prior to the date coverage is reduced or ends as described in the Group certificate as applicable.
2. The amount of insurance to be converted shall not be more than the amount of group insurance which ends.
3. The date of issue of any individual policy shall be the day following the last day of the period during which the Applicant has a right to convert the group insurance as described in the Group Certificate.
4. Any individual policy shall take effect as of its date of issue, but only if: (1) the Applicant has a right to convert his or her group insurance for the amount and plan of insurance applied for; and (2) this application has been made and the first premium, according to 5Star Life Insurance Company's published rates for the insurance applied for and the payment interval selected, is paid in full not later than the last day on which the Applicant has a right to convert his or her group coverage, as applicable.

Sign Here Applicant's Signature _____ Date _____



Payor Signature _____ Date _____

(If different than Applicant)

Owner Signature _____ Date _____

(If different than Applicant)

Signed at (City, State) _____