

Lincoln Financial Conversion Letter

(formerly Jefferson Pilot)

(date)

Name:

Address:

City, State Zip

Lincoln Financial Group Identifier: WBAIT _ _ _ _

(last four digits of your group policy number as shown on the Certificate of Coverage)

Dear

Your coverage(s) as noted below terminates on _____.

The conversion privilege allows you to convert to an individual LTD policy as applicable, without submitting evidence of insurability if all or part of your group insurance is terminated.

Long Term Disability Monthly Insured Salary _____

You may call Lincoln Financial at 800 423-2765 for a conversion quote. *You have only 31 days from date of termination to qualify for this benefit.* Their address is: Lincoln National Life Insurance Company (Lincoln Financial Group), P O Box 2616, Omaha, NE 68103-2616.

Please note that qualification for the conversion privilege is not a guarantee; please refer to your Long Term Disability certificate(s) for more information.

Sincerely,

Bank Personnel Name, etc

**EMPLOYEE APPLICATION FOR CONVERSION OF
GROUP LONG TERM DISABILITY INSURANCE**

1. Name _____
(Last) (Full First) (Middle)
2. Sex: _____ Male _____ Female 3. Social Security No. _____ / _____ / _____
4. Birthdate: Month _____ Day _____ Year _____ Home Phone No. (_____) _____
5. Home Address (Street & No.) _____
City _____ State _____ Zip Code _____
6. Application is being made according to the conversion privilege contained in Group Policy No. _____
Issued to _____
(Group Policyholder or Participating Employer) by The Lincoln National Life Insurance Company.
7. Occupation _____
8. Reason for requesting conversion:
____ You terminated employment on _____
____ Other (explain): _____
9. Your basic monthly earnings in effect just prior to your termination date: \$ _____
(NOTE: Show Basic Monthly Earnings as defined by the former plan, exclusive of overtime, bonus and other extra pay.)
10. Are you covered or eligible for any other Group Long Term Disability insurance, other than The Lincoln National Life Insurance Company plan shown in part 6 above? _____ Yes _____ No (NOTE: Your application will be declined if you become eligible for other group LTD coverage within 31 days after The Lincoln National Life Insurance Company coverage ends.)
11. Are you now disabled from a sickness or injury? _____ Yes _____ No Are you retired? _____ Yes _____ No
12. This Conversion Policy provides 60% of your last basic monthly earnings not to exceed a maximum monthly benefit of \$3,000, less other Income Benefits. However, this benefit percentage and maximum monthly benefit may not exceed the similar benefit percentage and maximum monthly benefit which were applicable to you on your termination date under former plan, less Other Income Benefits.
13. Premium Mode: Quarterly
If you apply for insurance in the middle of a quarter your premium will be prorated.

The statements set forth above are true to the best of my knowledge and belief, and may be relied upon by the Insurance Company in considering this application. Further, my signature below acknowledges that I have received a copy of my statements as they appear on this application.

Signature of Applicant _____ Date _____
Signature of Witness _____ Date _____
Position and Title _____

Please forward the original of this Application and your first quarterly premium payment to The Lincoln National Life Insurance Company, Group Insurance Service Office, P.O. Box 2616, Omaha Nebraska 68103-2616.

Your Insurance will not become effective until your employer has completed the EMPLOYER QUESTIONNAIRE and you receive approval and an effective date for your Long Term Disability Conversion Insurance from The Lincoln National Life Insurance Company.

LRA _____ License # _____

For Group Insurance Service Office Use Only:

**GROUP EMPLOYER QUESTIONNAIRE
FOR LONG TERM DISABILITY CONVERSION**

To be completed by the Employer and forwarded to The Lincoln National Life Insurance Company, Group Insurance Service Office, P.O. Box 2616, Omaha, NE 68103-2616, with the terminating employee's Application for Conversion.

The Conversion Privilege is only available to those insured employees who have been covered under their employer's long term disability plan for at least 12 consecutive months. The insured employee must terminate for one of the following reasons:

1. Employee resigned; or
2. Employee is terminated for cause; or
3. Employee is laid off beyond the limits provided in this employer's LTD plan; or
4. Employee elects to go on an uninsured leave of absence.

Please furnish the following data regarding the terminated Employee who is applying for Group Long Term Disability Conversion Coverage.

1. Employee Name:

2. Group LTD Policy No.: _____ Group ID#: _____

3. Employee's Date of hire: _____

4. Employee's effective date of insurance under your group LTD policy: _____

5. Date Employment terminated:
(The employee's date of termination should correspond with the date his or her insurance terminates.)

6. Employee's occupation on the date of termination: _____

7. Employee's last basic monthly earnings before termination: _____

8. Date notice of Conversion Privilege was given to the employee: _____

9. Was the employee covered under your present LTD policy (or policies) for at least 12 consecutive months?
_____ Yes _____ No

10. Did the employee leave employment as a result of retirement? _____ Yes _____ No

11. Is the employee now disabled from a sickness or injury? _____ Yes _____ No

12. Is there a disability claim for this employee pending for disability benefits under your LTD policy?
_____ Yes _____ No

To the best of my knowledge the above information given is correct and complete.

Name of Employer as it appears on the Group Policy _____

Employer's Name and Address (if a subsidiary or an affiliated Company) _____

Preparer's Signature and Title _____ Date _____