Notice of Continuation of Coverage

As a terminated employee – or as an active employee or retiree – losing coverage or a portion of coverage under your employer's Group plan, you may be eligible to continue all or a portion of that coverage without submitting evidence of good health. Potential options are explained below. The specific options available to you are based on the provisions as defined in the Group plan. Included with this notice is a form you can submit to obtain additional information. Based on your selection, you will receive a personalized quote, details on the specific coverage available to you, and the necessary form to enroll.

Life Conversion

The Life Conversion option provides the opportunity for you to obtain an individual life insurance policy that accumulates cash value and is offered at individual insurance rates. There are no mandatory age reductions and coverage can continue with premium payment until the Scheduled Maturity Date (generally age 100 or 120, depending on the policy version) at which time the Cash Surrender Value is paid to the insured.

If coverage is ending because The Hartford Group Life policy is terminating or coverage for a class of employees is terminating, some restrictions may apply. If coverage is ending for any other reason, you can generally convert up to the full amount of your terminating coverage. Conversion is also available to your dependents if they had coverage under your group plan. Residents of New York and West Virginia have the option for an 11-month term policy prior to the permanent life policy becoming effective. **Premiums for a Life Conversion policy are substantially higher than your Employer Group plan rates.**

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Attached is a form that contains additional information about continuing coverage. You can use this to request a quote and the necessary forms to enroll.

Please note that there is a designated timeframe during which you can exercise your coverage continuation options. To continue coverage, **you must mail or fax this form to request information within 15 days from the date of this notice or 31 days from your group coverage termination date, whichever is later. Under no circumstances, however, will continuation of coverage be available beyond 91 days from your group coverage termination date. Any issues regarding late notification by your employer must be addressed with the employer.**

If you have questions about this information, your eligibility, or the status of any request you have submitted, please call a representative at **1-877-320-0484.**

The Hartford, Portability and Conversion Unit
P.O. Box 248108
Cleveland, OH 44124-8108

Fax 1-440-646-9339

Frequently Asked Questions

Q: If I request a quote, how does Hartford determine the amount of coverage to quote?
A: Hartford will contact your employer to obtain the amount of coverage you had in effect under the group plan. The quote is based on this amount as well as applicable plan provisions.

Q: If I receive a quote for coverage, does this mean I qualify for the coverage amount quoted?
A: The amount quoted is not a guarantee that a policy will be issued in that amount. Upon receipt of your application for coverage, Hartford will perform an eligibility review to determine that the amount of coverage you have requested can be granted based on the coverage you had in effect under the group plan as well as plan provisions.

Q: What is my policy effective date?
A: The Group Life policy has a 31-day grace period; hence the effective date of a Life Conversion policy is the 32nd day following the group coverage termination date.

Q: If my application for coverage is not approved by the effective date, am I still covered?
A: Yes, if your application is approved the effective date of your policy will be retroactive to the date indicated above.

Q: I understand that there is no medical underwriting or physical exam required but can I still be denied for coverage?
A: Your request for coverage can be denied if you do not meet the timeliness requirement. You must mail or fax this form to request information within 15 days from the date of this notice or 31 days from your group coverage termination date, whichever is later. Under no circumstances will continuation of coverage be available beyond 91 days from your group coverage termination date. Coverage can also be denied if it exceeds the amount you had in effect under your employer's Group plan or if it does not align with you employer's plan provisions. In addition, any request for coverage that is not available under your employer's Group plan will also be denied.

Q: If I start to work for a new employer and obtain coverage under that employer's Group plan, will that Group coverage impact any conversion or portability policy that I may have purchased?
A: If you obtain coverage under a new employer's Group plan, your portability or conversion policy will remain in effect provided you continue to pay the required premiums. However, benefits under conversion policies may be affected by the amount of your other coverage.

Clear Form

Notice of Continuation of Coverage

Employer: INSTITUTE OF AMERICAN INDIAN ARTS Policy #:_____

The following information is to be completed by Employer or Employer Representative

Employee Name:_____ Employee ID#:_____ Date:_____

Last Day Worked (or date employee is no longer in an eligible class):_____

Date of Group Coverage Termination:_____ Termination Reason:_____

Signature_____ Print Name_____

Email Address_____ Telephone_____

As noted in the descriptive information, Life Conversion is available without submission of evidence of good health. The rates for Life Conversion will be substantially higher than your employer Group plan rates.

Life Conversion rates are quoted and billed quarterly.

Employee: To request specific rates and enrollment information, please complete the information below and mail or fax this entire page to:

The Hartford, Portability and Conversion Unit, P.O. Box 248108, Cleveland, OH 44124-8108
Fax 440-646-9339, Phone 877-320-0484

Yes, I am interested in receiving the information checked below.

☐ Life Conversion Quote

Please print the following information:

Name:_____ Date of Birth:_____

Social Security # **(indicate last 4 digits only):**_____

Address:_____

City:_____ State: _____ Zip Code:_____

Telephone Number:_____ Email:_____

I am interested in receiving information for the following persons:

☐ Myself ☐ My Spouse ☐ My Child(ren)

Please print the name(s), relationship, and date(s) of birth for each dependent who may be eligible for coverage. Include an additional sheet if necessary.

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

Name:_____ Relationship:_____ Date of Birth:_____

I understand that I have only 31 days from the date of my group coverage termination OR 15 days from the date of this notice, whichever is later, to complete and submit this form to The Hartford. In no event, however, will my eligibility to continue coverage exceed 91 days from my group coverage termination date.

_____ _____

Signature (required) **Date**