

Life Insurance

## Term Life Conversion Application General Information

This form is used to convert in force term insurance coverage for a Primary Insured on a single life term policy, or an insured on an Other Insured Rider (OIR) or Children's Term rider, to a permanent plan of insurance, where evidence of insurability is not required.

To convert your term coverage, premiums on your existing policy:

1. must be current; and

## 2. may not currently be waived under the Waiver of Premium Benefit.

For information on eligibility and conversion amounts, please refer to the section in your policy or rider that outlines your right to convert coverage.

If insurance exceeding the conversion limit is requested, or if riders or benefits that require evidence of insurability are requested, please complete the Application for Life Insurance, form L-3-55.

**IMPORTANT:** Please answer the medical questions on page 2 of the Adjustment Application and submit them with the Conversion Application if you are:

• Adding the Accelerated Benefit Rider

Applying for a non-tobacco rate

If applying for the Long Term Care Rider, please complete the Long Term Care Application Supplement.

These additions/changes are subject to underwriter approval.

Please Note: In order to maintain continuous coverage, the cancellation date of the existing policy will be determined by the Home Office. The effective date of the new policy will immediately follow the cancellation date of the existing policy. The new policy will be issued at that time.

If the owners's resident address is a PO Box, please provide a street address in the Special Instructions/Home Office Endorsements section.

#### Billing Modes and Monthly Easy Pay Authorization (EFT)

Please select	<ul> <li>Monthly Easy Pay (EFT)</li> <li>Complete account information (only if Monthly Easy Pay is selected)</li> </ul>						
either Monthly	Bank Name						
Easy Pay or	Account Number						
choose from	Transit/ABA Number (9 digits)						
the additional	Type of Account*		Checking*		avings*		
modes below.	Payment Included			Amount Collec			
If Monthly Easy	Withdrawal Date 🔸	The withd	rawal date will be the san	ne as the effective date a	nd one month c	of premium is required	
Pay is selected,		unless backdated.					
please		• If the application requires a withdrawal date other than the policy effective date, the following					
complete		rules apply:					
account		<ul> <li>The withdrawal date must be between the 1st and 28th</li> <li>An additional month of promium will be required</li> </ul>					
information.	<ul> <li>An additional month of premium will be required</li> <li>Withdrawal date requested: of each month</li> </ul>						
└ <b>─</b> ►	<ul> <li>Direct Billing (for Modes other than Monthly)</li> <li>Annual</li> <li>Semi-Annual</li> <li>Quarterly</li> </ul>						
	🗋 Annual 🗋 Sei	mi-Annuai	🗆 Quarteriy				
	(Grange) to withdraw authorization will ren Note: The initial premiu based on information	<b>funds from</b> nain in effe um will aut provided - <b>1</b>	nation and my financial i my checking or savings ct until Grange has recei omatically be charged up There is no advance notif ent monthly payments w	account to pay premiun ved a written request to oon underwriting approve ication. Please maintain	<b>ns on my life ins</b> <b>terminate this</b> al/acceptance f sufficient acco	<b>surance policy. This</b> agreement. rom the account above unt balance to cover	
				Dated	/	/	
	Applio	cant Signatur	re				



Grange Life Insurance Company 671 South High Street, PO Box 1218 Columbus, OH 43216-1218 800-399-3797

## Illustration Certificate (Required for Heritage UL and Accumulation UL.)

Applicant: I acknowledge that an illustration conforming to the policy applied for was not provided at this time, but understand that an illustration conforming to the issued policy will be provided to me no later than at the time of policy delivery.

Applicant Signature

Date

I certify that no illustration was presented at the time of application; or, I certify that I did not provide an illustration conforming to the policy applied for:

Agent Signature

# **Term Life Insurance Conversion Application** *Please print using dark ink.*





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# **Proposed Insured Information**

Name (First	MI	Last)	Date of	Birth /			
Address				,			
City	State	Zip	Muni	cipalit	y State o	of Birth (country if not US)	
Conversion of Policy Number				G	ender		
□ Term Policy □ Other Insur □ Child's Rider	ed Rider				🗆 Male 🗆	Female	
Check here if this rider should be terminated (i.e. there are no other children to be covered).					Is the applicant the owner of the Policy?		
Please Note: This rider will rer	nain in force i	f the box above is	not checked				
Owner Information for Convert	ed Policy (if	left blank, the pro	oposed insur	ed will	l be the owner o	of the converted policy)	
Name (Full Legal Name) (First		Last) Date of Birth		ate of Birth	Social Security Number		
Address							
City		State	Zip		Municipality		
Payor Information (if different from owner address)							
Name (First	MI	Last)	Date of		th Social Security Number		
Address				/	L		
City		State	Zip	Zip Municipality			
Request for Conversion							
Plan Requested: Universa	ILife □Who	le Life					
For Universal Life:							
Planned Premium:	Planned Premium: Death Benefit Option 7702 Compliance Test						
		<ul> <li>Level (Default)</li> <li>Increasing</li> </ul>			□ GPT (Default) □ CVAT		
For Whole Life:							
Select One: 🗋 Lifetime Pay 🗋 20 Pay 🗋 Final Expense Nonforfeiture: Reduced paid-up insurance is the only option.							
Complete for all policies:							
Amount of Coverage Requested: \$							
Is this the full amount of current policy?  Yes Ves No If "no," balance should be: Continued Cancelled*							
* Please note that if the balance is cancelled, the conversion privilege for that amount is forfeited.							
The following benefits may be selected only if they were included in the original policy:Accidental DeathYesNoWaiver of Premium*YesNoChild RiderYesNo							
You can apply for the Long Term Care Rider if it is available on the plan requested. This rider is subject to underwriting approval.							
Long Term Care**  Yes No							
* If the insured is disabled as defined in the Waiver of Premium Provision, this benefit may not be selected.							
** The LTC Supplemental Application must be provided (L-3-72 or L-3-72 (IN) for the applications signed in Indiana). The original policy is required to be returned. Please check one of the following:							
□ I am returning the entire policy. □ The policy has been lost or destroyed.							

Please print using dark ink.



# Beneficiary Designation

Primary:					
Name	Relationship	% Share	Social Security Number		
Name	Relationship	% Share	Social Security Number		
Contingent:					
Name	Relationship	% Share	Social Security Number		
Name	Relationship	% Share	Social Security Number		
If there is an irrevocable beneficiary or an assign the approval of the irrevocable beneficiary or ass applicable to the new policy.					
			/ /		
Signature of Irrevocable Beneficiary or Assignee			Date		
			/ /		
Signature of Witness			Date		

## Other Insurance Information

1. Has the applicant, proposed insured, owner (if other than the applicant) or any beneficiary entered or made plans to enter into any agreement or contract to sell or assign the ownership of a beneficial interest in the applied for policy?	Yes No
2. Has the applicant, proposed insured, owner (if other than the applicant), or any beneficiary, ever sold, transferred or assigned any life insurance policy to a third party, such as a viatical settlement entity, life settlement entity, insurance company, other secondary market provider, or premium financing entity?	
3. Has any party to the application ever received or will receive any inducement, fee or compensation as an incentive to purchase, sell, transfer or assign a policy?	
4. Has any person promised or agreed to give or has given to any party to this application any inducement, fee or compensation as an incentive to purchase the applied for policy?	
5. If the answer to any question above is yes, please provide details regarding the agreement, incentive or transaction.	

Please print using dark ink.



## Agreement and Authorization

**REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION:** Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

I/We represent to Grange Life Insurance Company that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that the Company can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed.

The **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

**FRAUD NOTICE:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

#### Proposed Insured and Owner Signatures

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

- (1) All such statements and answers shall be the basis for and a part of any policy issued on this application.
- (2) No agent or medical examiner can accept risks or make or change contracts or waive Grange's rights or requirements.
  (3) No insurance shall take effect until (a) a policy is issued on this application and delivered and accepted by the owner and (b) the first premium due is paid in full while each proposed insured is alive.
- (4) Acceptance of a policy by the Owner shall constitute ratification of any changes made by Grange under "Special Instructions / Home Office Endorsements."

		/ /
Proposed Insured Signature		Date
		/ /
Owner Signature (if other than ap	plicant)	Date
		/ /
Signature of the Owner of Original Policy (this is the owner of the policy from which this conversion is being processed - <b>this signature is required</b> )		Date
		/ /
Agent Signature	Agent Number	Date
Signed at (City and State)		on (Month/Day/Year) /

## Special Instructions / Home Office Endorsements