Group Level Term Life Conversion Application

NAME				OCCUPATION	
First	Middle Initial	Last			
Home Address				**LAST 4 DIGITS OF SOCIAL SECURITY NO.**	**HOME PHONE**
Street	City	State	Zip		
BENEFICIARY				RELATIONSHIP TO APPLICANT	
First	Middle Initial	Last			
CONTINGENT BENEFICIARY				RELATIONSHIP TO APPLICANT	
First	Middle Initial	Last			

	Month	Day	Year	Age Last Birthday	
Date of Application					Amount of Insurance
Date of Birth					$
Sex		**Birthplace (State)**			**Annual premium**
Male Female					$

Has the insured used tobacco in any form in the last 12 months? Yes No

Mode of Payment: Monthly Annual Semi Annual

Initial Premium $_____

_____

SIGNATURE OF APPLICANT (Owner)

_____

Date

Submit Application to:

Combined Insurance
Attn: Yaunie Douglas
1000 Milwaukee Ave
Glenview, IL 60025

Or fax to: 1-847-953-8100
Questions call 1-847-953-8436