

6. EMPLOYER TO COMPLETE – PRINT OR TYPE

Applicant's name					
Employer's name			Group account number		Unit number
Employer's address		City	State	ZIP	Phone number ()
Date applicant last worked / /		Date insurance terminated (if different from date last worked) / /			
If date last worked differs from date insurance terminated, explain:					
If applicant ceased work due to illness or injury, has he or she been offered any applicable continuation rights due to disability? <input type="checkbox"/> yes <input type="checkbox"/> no (Please consult your group policy or administrative instructions.)					
Maximum amount eligible for conversion on termination date \$ _____					
_____		_____		_____	
(Signature of planholder)		(Title)		(Date)	