



**SECURITY MUTUAL LIFE**  
 INSURANCE COMPANY OF NEW YORK  
 SECURITY MUTUAL BUILDING • 100 COURT ST.  
 P.O. BOX 1625 • BINGHAMTON, NY 13902-1625  
 607-723-3551 • www.sm1ny.com

**NOTICE OF CONVERSION PRIVILEGE**

To: \_\_\_\_\_  
(Name)

\_\_\_\_\_ \$ \_\_\_\_\_  
(Policy No.)                      (Certificate No.)                      (Amt. Life Ins.)                      (Effective Date)                      (Date of Notice)

Your group life insurance was terminated (or reduced by \$ \_\_\_\_\_ ) as of \_\_\_\_\_  
month                      day                      year

You are hereby notified that the above policy contains a conversion privilege which will permit you, if eligible, to convert your group life insurance to the extent therein provided, to an individual policy of life insurance.

Application forms and premium rates may be obtained by completing the applicable sections on the back of this form and mailing at once to:

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK  
 GROUP DEPARTMENT  
 P.O. BOX 1625  
 BINGHAMTON, NEW YORK 13902

Under the conversion privilege you are required to make written application for an individual policy and pay the first premium within:

- (a) 31 days from the date of termination (or reduction) shown above, or
- (b) 15 days from the date of this notice, whichever is later, provided however, that if this notice is not given within 90 days after the date of termination (or reduction), the time allowed for exercising the conversion privilege shall expire at the end of such 90 days.

Please refer to your Certificate for additional information about your conversion privilege.

Signed \_\_\_\_\_

(Name of Employer)

Date: \_\_\_\_\_

Note to Employer: Please indicate reason for termination of group insurance:

- Termination of employment.
- Termination of membership in class eligible for insurance.
- Voluntary discontinuance of required premium contributions by employee.

I am interested in making application under the conversion privilege for an individual life insurance policy.

The following information should be furnished:

Full Name: \_\_\_\_\_

Date of Birth: month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: (      ) \_\_\_\_\_

\_\_\_\_\_  
(Employee Signature)

\_\_\_\_\_  
(Date Signed)

**THIS IS NOT AN APPLICATION  
PLEASE DO NOT SEND ANY MONEY WITH THIS FORM.**