GROUP LIFE CONVERSION APPLICATION
Reliance Standard Life Insurance Company

This form is to be used only when an eligible person desires to convert his Group Life insurance to an Individual policy. This form must be completed in full and submitted to the Company within 31 days following the effective date of termination of insurance. The top portion of this form is to be completed by the policyholder, the lower portion by the applicant. You may wish to refer to your policy=s Schedule of Benefits page to complete some of the questions on this application.

When all areas are complete, mail to:

Insurance Services
Division of Protective Life Insurance Company
Post Office Box 12686
Birmingham, AL 35202-6686

TO BE COMPLETED BY POLICYHOLDER

Name and Address of Group Policyholder and, if applicable, Division Name:_____
_____ Policy No.:_____ Policy Eff. Date:_____
Insured=s Full Name: _____ Male _____ Female ____
Date of Birth: _____ Annual Salary/Earnings: $_____
Social Security No.: _____ Date Employment Began: _____
Occupation/Job Title: _____ Date Last Worked: _____
Scheduled Work Hours: _____/week Insured=s Premium Paid To: _____
Insured=s: Effective Date: _____ Insurance Class: _____ Insurance Amount: Basic $_____ Supp $_____
Reason Insured Stopped Work (specify): _____ Dependent Amt: $_____
Conversion Rights Exercised Due To (check applicable response):
_____ (1) Employee Terminated Employment On: _____
_____ (2) Group Policy Terminated On: _____
_____ (3) Disability of the Insured On: _____ Has A Waiver of Premium Claim Been Submitted to RSL? Yes___ No___
If No, Please Explain: _____
_____ (4)Other, Please Explain: _____
I have reviewed the information set forth, and represent that to the best of my knowledge and belief it is true and correct.

_____ _____ _____
Signature Of Policyholder=s Authorized Representative Title Date Signed

(_____)_____ _____
Phone Number of Representative Federal Employer Identification Number

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TO BE COMPLETED BY APPLICANT

I would like to convert $_____ of my group life insurance coverage that was in-force prior to the termination date.
Desired Mode of Premium Payment _____Quarterly _____Semi-Annually _____Annually

Beneficiary Designation
Upon the death of the insured, the proceeds of the policy to which this application is attached shall be paid as follows:
Primary Beneficiary(s)
Name_____ Address_____ Relationship_____ Percentage_____
Name_____ Address_____ Relationship_____ Percentage_____
Contingent Beneficiary(s)
Name_____ Address_____ Relationship_____ Percentage_____
Name_____ Address_____ Relationship_____ Percentage_____
If more than one primary beneficiary is named and no percentage is indicated, payment will be in equal shares to the surviving primary beneficiary(s). If there are no surviving primary beneficiary(s), the proceeds will be paid to the contingent beneficiary(s). If more than one contingent beneficiary is named and no percentage is indicated, payment will be in equal shares to the surviving contingent beneficiary(s). If there are no surviving contingent beneficiary(s), the proceeds will be paid to the executors, administrators, or assigns of the owner.

Applicant=s Address_____
City,State, Zip Code_____ Phone (_____)_____

I have reviewed the information set forth above and represent that to the best of my knowledge and belief it is true and correct.

Signature_____ Date Signed_____