

NASA EMPLOYEES BENEFIT ASSOCIATION
NOTICE OF CONVERSION PRIVILEGE

Name of Employee _____

Social Security No. _____

Date of Birth _____

Date Insurance Terminated _____

(Note: The conversion information must be requested 31 days prior to the Termination date)

Reason: _____

Employee enrolled in:

Basic amount: _____

Optional amount: _____

Dependent spouse/amount: _____

Covered children under age 19: _____

For conversion information mail this form to:

Great West Life
Health Conversion Department
800-537-2033, extension 73962

Signature of
NEBA Chapter Officer

Date