

Group Life Insurance Enrollment

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Group Administration Department • 400 Robert Street North • St. Paul, Minnesota 55101-2098

EMPLOYER NAME: State of Ohio

POLICY NUMBER: 34301

1. Complete the reason for enrollment and sections A, B, and E.
2. If you are electing coverage on your dependents, complete sections C and/or D.
3. Return completed and signed form to Minnesota Life at the address above.

Reason for enrollment

New Hire Family Status Change Newly Eligible Exempt Status Annual Open Enrollment

A. EMPLOYEE INFORMATION

First name _____ Middle initial _____ Last name _____

Email address _____

Street address _____ City _____ State _____ Zip code _____

Have you used tobacco in any form during the past twelve months or are you currently using nicotine in any form? Yes No

Date of birth _____ State of Ohio user ID _____ Date of employment _____ Gender
 Male Female

Total amount of supplemental term life insurance requested (\$10,000 increments to a maximum of \$600,000 or 8 times the employee's calculated annual rate) \$ _____

B. BENEFICIARY INFORMATION (EMPLOYEE IS THE BENEFICIARY OF ANY DEPENDENT COVERAGE)

| Primary beneficiary name(s) and address | Relationship | Share % (must total 100%) |
|--|--------------|---------------------------|
| | | |
| Contingent beneficiary name(s) and address (<i>Contingent beneficiaries collect only if all primary beneficiaries predecease the insured.</i>) | Relationship | Share % (must total 100%) |
| | | |

C. SPOUSE INFORMATION

First name _____ Middle initial _____ Last name _____

Email address _____

Have you used tobacco in any form during the past twelve months or are you currently using nicotine in any form? Yes No

Date of birth _____ Social Security number _____ Gender
 Male Female

Total amount of insurance requested (\$10,000 increments to a maximum of \$40,000)
\$ _____

D. CHILDREN INFORMATION

List of names and dates of birth for your eligible children

Total amount of insurance requested

\$7,000

E. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee signature _____ Daytime telephone number _____ Evening telephone number _____ Date signed _____

X