

## 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 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.

**A. EMPLOYEE INFORMATION**

First name \_\_\_\_\_ Middle initial \_\_\_\_\_ Last name \_\_\_\_\_

Email address \_\_\_\_\_

Street address	City	State	Zip code
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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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 <b>X</b>	Daytime telephone number	Evening telephone number	Date signed
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