Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
Group Customer Service • 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 ☐ Newly Eligible Exempt Status ☐ Annual Open Enrollment ☐ Family Status Change Marriage Date: _____
Birth/Adoption Date: _____

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, whichever is less) $

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 *(Contingent beneficiaries collect only if all primary beneficiaries predecease the insured.)*	Relationship	Share % (must total 100%)

C. SPOUSE INFORMATION - Must maintain a minimum of $10,000 employee supplemental coverage in order to apply for spouse coverage

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 - Must maintain a minimum of $10,000 employee supplemental coverage in order to apply for child coverage

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 phone number	Evening phone number	Date signed
X			