

Group Life Insurance Enrollment

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Group Administration Department • 400 Robert Street North • St. Paul, MN 55101-2098 • Fax: 651-665-4827

EMPLOYERNAME: State of Arkansas

POLICY NUMBER: 33432

Agency Name: _____ **Agency Code:** _____

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 using the above address or fax number.

A. EMPLOYEE INFORMATION

First name _____ Middle initial _____ Last name _____

Email address _____

Street address _____ City _____ State _____ Zip code _____

Date of birth _____ Social Security number _____ Date of employment _____ Gender
 Male Female

Basic Term Life and AD&D (Employer Benefit)

ACCEPT \$10,000 employer benefit DECLINE \$10,000 employer benefit

Basic Contributory Term Life and AD&D

None \$30,000

Supplemental Term Life and AD&D

None \$ _____ (\$1,000 increments to \$250,000)

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

First name _____ Middle initial _____ Last name _____

Email address _____

Date of birth _____ Social Security number _____ Gender
 Male Female

Dependent Term Life (Active Legislators and Constitutional Officers)

None \$20,000 \$40,000

Dependent Term Life (All other employees)

None \$4,000 \$8,000 \$12,000 \$16,000 \$20,000 \$40,000

D. CHILDREN INFORMATION

List of names and dates of birth for your eligible children

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 knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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