

Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • 18-3789 • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME:

POLICY NUMBER:

1. Return completed and signed form to
2. Please complete the Group Life Evidence of Insurability form for coverage that is not guaranteed.

A. EMPLOYEE INFORMATION

First name		Middle initial	Last name	
Email address				
Street address		City	State	Zip code
Will the insurance applied for replace or change an existing policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of birth		Date of employment	Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

B. SPOUSE INFORMATION

First name		Middle initial	Last name	
Email address			Marriage date	
Will the insurance applied for replace or change an existing policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of birth	Social Security number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

C. CHILDREN INFORMATION

List of names and dates of birth for your eligible children:

D. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for insurance coverage.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Employee signature X	Daytime telephone number	Evening telephone number	Date signed
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FOR HOME OFFICE USE ONLY:

Agent/broker/registered representative		Agent's Florida license identification number	
Agent's signature X	AGENT: To the best of my knowledge and belief, will the insurance applied for replace or change an existing policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	