

Optional Group Life Insurance Enrollment

Minnesota Life Insurance Company, a Securian Financial Group affiliate
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: Lee County Government

POLICY NUMBER: 33441

1. Enrollment/Increase/Late Application: circle one
2. Complete sections A, B, and E.
3. If you are electing coverage on your dependents, complete sections C and/or D.
4. Submit signed form to your Human Resources Department.
5. If you are electing coverage more than 31 days after initial eligibility, or you are a new hire electing more than \$200,000 of coverage, complete an Evidence of Insurability form and submit it to Minnesota Life at 400 Robert St N, St. Paul, MN

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Total amount of insurance requested (\$1000 increments from \$25,000 to \$500,000 - not to exceed 10 times salary) \$				
Has it been more than 31 days since you became eligible to apply for this benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No				

B. OPTIONAL GROUP LIFE 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		
Total amount of insurance requested (\$1,000 increments from \$25,000 to \$250,000 - not to exceed 50% of employee's Optional coverage) \$				

D. CHILDREN INFORMATION - (List of names and dates of birth for your eligible children)

Total amount of insurance requested (\$5,000 increments to \$25,000 - not to exceed 50% of employee's Optional coverage)
\$

E. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for supplemental 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

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	