

# Group Life Insurance Enrollment Worksheet



A Securian Company

## MINNESOTA LIFE

**EMPLOYER NAME:** Liberty Elementary School District #25

**LIFE POLICY NUMBER:** 34553

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

### A. EMPLOYEE INFORMATION

First Name		Middle Initial	Last Name	
Street Address		City	State	Zip Code
Date of Birth (Month, Day, Year)	Social Security Number	Date of Employment	Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### B. BASIC LIFE

Amount \$ \_\_\_\_\_ Insurance Class: \_\_\_\_\_ Effective Date: \_\_\_\_\_

### C. SUPPLEMENTAL LIFE

<b>Employee</b> Current Amount \$ _____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease	Amount \$ _____	Grand Total \$ _____	Effective Date _____
<b>Spouse</b> Current Amount \$ _____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease	Amount \$ _____	Grand Total \$ _____	Effective Date _____
<b>Child</b> Current Amount \$ _____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease	Amount \$ _____	Grand Total \$ _____	Effective Date _____

### D. SPOUSE INFORMATION

First Name		Middle Initial	Last Name	
Date of Birth (Month, Day, Year)	Is your spouse also an employee covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

### E. CHILDREN INFORMATION – (List names and date of birth for your eligible children)

### F. AUTHORIZATION

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

Employee Signature	Daytime Telephone Number	Evening Telephone Number	Date Signed
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