

Group Life Insurance Change Request

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B2-4930 • St. Paul, Minnesota 55101-2098

EMPLOYER NAME: State of Arkansas

POLICY NUMBER: 33432/33553

RETURN COMPLETED FORM TO MINNESOTA LIFE

EMPLOYEE INFORMATION

First name	Middle initial	Last name	Member/Employee #	
Email address				
Street address	City	State	Zip code	
Date of birth	Social Security number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Agency name	Agency code		Date of hire	

SUPPLEMENTAL LIFE COVERAGE

For Employees, Legislators and Constitutional Officers

If changing, elect the applicable box and/or identify the applicable amount in \$1,000 increments.

Active Legislators and Constitutional Officers maximum = \$50,000. All other active employees maximum = \$250,000.

Decrease total to \$ _____ Increase total to \$ _____ (according to the provisions of the policy)
An evidence of insurability (EOI) will be sent to you for increases.

Cancel my supplemental coverage.

SPOUSE AND CHILDREN INFORMATION

For Dependents of Employees

Unit(s)/Insurance amount

- 1 unit - \$4,000 3 units - \$12,000 5 units - \$20,000
 2 units - \$8,000 4 units - \$16,000 Cancel

For Dependents of Legislators and Constitutional Officers

Unit(s)/Insurance amount

- 1 unit - \$20,000 2 units - \$40,000 Cancel

List ALL dependents to be covered for one or more unit(s) of Dependent Life Insurance. Dependents NOT listed will not have coverage.

Person proposed for insurance - Name (last, first, middle initial)	Relationship	Date of Birth

SPECIAL REQUESTS

Include any special comments or requests here (Continue on back if necessary).

Minnesota Life may send you additional forms for completion before your change request is processed. Minnesota Life shall incur no obligation because of any of the above request(s) unless we have approved the requested change(s) in writing.

AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for employee-paid 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 X	Daytime telephone number	Evening telephone number	Date signed
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Send to: Minnesota Life, Group Term Life - B2-4930, 400 Robert Street North, St. Paul, MN 55101-2098,
Fax 651-665-4827.



Questions? Please call 1-888-826-2734.