

Group Life Insurance Enrollment

Minnesota Life Insurance Company, a Securian Financial Group affiliate
400 Robert Street North • B2-4930 • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: State of Arkansas

POLICY NUMBER: 33432

RETURN COMPLETED FORM TO MINNESOTA LIFE

A. 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	

B. BASIC LIFE COVERAGE (\$10,000 coverage PAID for by the state of AR)

I hereby apply for the following Basic Life coverage (if not currently enrolled)

- Employee \$10,000 (paid for by state of AR) Legislators and Constitutional Officers \$10,000 (paid for by state of AR) Legislators and Constitutional Officers Basic Life of \$30,000
- Declination - I do not wish to participate/continue under the State Employees' Group Life plan. I understand that I will have to furnish proof of good health if I apply at a later date.

C. SUPPLEMENTAL LIFE COVERAGE

For Employees, Legislators and Constitutional Officers

I hereby apply for \$_____ (\$1,000 increments)

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

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

For Dependents of Legislators and Constitutional Officers

Unit(s)/Insurance amount

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

D. SPOUSE AND CHILDREN INFORMATION (Complete if applying for dependent coverage.)

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

E. 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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