Group Life Insurance Enrollment

MINNESOTA LIFE

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

Effective Date: / /

EMPLOYER NAME: PALM TRAN **POLICY NUMBER: 33696**

1. Complete sections A, B, and E.
2. If you are electing coverage on your dependents, complete sections C and/or D.
3. Return complete and signed form to your Human Resources representative.

A. EMPLOYEE INFORMATION

First name	Middle initial	Last name

Street Address	City	State	Zip code

Will the insurance applied for replace or change an existing policy? ☐ Yes ☐ No

Date of birth	Social Security number	Date of employment	Gender ☐ Male ☐ Female

Total amount of basic term life and AD&D insurance provide (employer-paid)

☒ $25,000 basic life ☒ $15,000 basic AD&D (employees age 70 and older have 50 percent of this coverage)

Total amount of additional term life and AD&D insurance requested ($10,000 increments to a maximum of $300,000)

$ ___________________________ ☐ Decline additional term life and AD&D

B. BENEFICIARY INFORMATION - EMPLOYEE IS THE BENEFICIARY OF ANY DEPENDENT COVERAGE

Primary beneficiary name(s) and address

First name Last name	Address	Relationship	Share %(must total 100%)
1			
2			
3			
4			
5			

Contingent beneficiary name(s) and address (Contigent beneficiaries collect only if all primary beneficiaries predecease the insured.)

First name Last name	Address	Relationship	Share %(must total 100%)
1			
2			
3			
4			
5			

C. SPOUSE/DOMESTIC PARTNER INFORMATION (marriage/domestic partner certificate required)

First name	Middle initial	Last name

Will the insurance applied for replace or change an existing policy? ☐ Yes ☐ No

Date of birth	Social Security number	Gender ☐ Male ☐ Female

Total amount of insurance requested($5,000 increments up to $50,000 or 100% of the employees total amount, whichever is less

$___________________________ ☐ Decline addition term life and AD&D

D. CHILDREN INFORMATION (eligibility: ages from birth to 25 years old only -- birth certificate required)

List all name & dates of birth for your eligible children (attach a separate sheet if necessary)

First Name Last Name	D.O.B.	Relationship	First Name Last Name	D.O.B.	Relationship
1)			4)		
2)			5)		
3)			6)		

Total amount of insurance requested

☐ $5,000 ☐ $10,000 ☐ Declined child coverage

E. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any 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 nu	Evening telephone number	Date signed