Supplemental Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North ● B1-3102 ● St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: Lake County BCC **POLICY NUMBER: 33654**

1. Complete sections A and D.
2. If you are electing coverage on your dependents, also complete sections B and/or C.
3. Complete a Beneficiary Designation form.
4. Return completed forms to the Lake County Office of Employee Services.
5. If medical underwriting is required, Minnesota Life will mail to you an Evidence of Insurability form.

A. EMPLOYEE INFORMATION

First name	Middle initial	Last name	Employee ID number

Email address

Street address	City	State	Zip code

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

Total amount of life insurance requested ($10,000 increments; not to exceed the lesser of 5 times salary or $300,000)
$

Total amount of AD&D insurance requested ($10,000 increments; AD&D amount not to exceed life amount)
$

B. SPOUSE INFORMATION

First name	Middle initial	Last name

Email address

Date of birth	Social Security number	Gender ☐ Male ☐ Female

Total amount of life insurance requested ($5,000 increments; not to exceed the lesser of $150,000 or 50% of employee's life amount)
$

Total amount of AD&D insurance requested ($5,000 increments; AD&D amount not to exceed life amount)
$

C. CHILDREN INFORMATION - List name, date of birth and gender for each eligible child

Name of child	Date of birth	Gender ☐ Male ☐ Female
Name of child	Date of birth	Gender ☐ Male ☐ Female
Name of child	Date of birth	Gender ☐ Male ☐ Female
Name of child	Date of birth	Gender ☐ Male ☐ Female
Name of child	Date of birth	Gender ☐ Male ☐ Female
Name of child	Date of birth	Gender ☐ Male ☐ Female

Total amount of life insurance requested ($2,500 increments; not to exceed the lesser of $10,000 or 50% of employee's life amount)
$

Total amount of AD&D insurance requested ($2,500 increments; AD&D amount not to exceed life amount)
$

D. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary.

Employee signature	Daytime telephone number	Evening telephone number	Date signed
X			

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Effective date	HR rep initials