

Public School Employee ARBenefits Group Term Life Enrollment and Service Request

Minnesota Life Insurance Company - A Securian Company
 Group Customer Service • 400 Robert Street North • St. Paul, MN 55101-2098 • Phone 1-888-826-2734 • Fax 651-665-4827

SPONSORNAME: ARBenefits Life **Sponsor Code:** _____ **POLICY NUMBER:** 33432/33553

Reason for Enrollment: New Hire/Date: _____ Rehire/Date: _____ Transfer Annual Open Enrollment

FAMILY STATUS CHANGE - EOI may be required if elected coverage is above GI amount.

Family Status Change: Marriage Divorce Birth/Adoption

REQUIRED: Please provide a copy of the marriage license, divorce decree, birth certificate, or certificate of adoption if selecting Family Status Change. If the document is not attached, this request cannot be processed. (Please complete coverage elections in the Employee, Spouse, or Child coverage sections.)

Spouse Term Life: \$ 1,000 increments up to \$50,000 Total coverage amount elected \$ _____ Cancel

Spouse name: _____ Spouse Social Security number: _____ Spouse date of birth: _____

Child Term Life: \$ 1,000 increments up to \$50,000 Total coverage amount elected \$ _____ Cancel

Child name: _____ Child Social Security number: _____ Child date of birth: _____

If more room is needed add another sheet of paper.

EMPLOYEE INFORMATION

Employee's full name (please print)	Date of birth	Social Security number
Mailing address		Phone number

EMPLOYEE TERM LIFE - EOI may be required if elected coverage is above GI amount.

Basic Term Life and AD&D: \$10,000 Coverage is automatic Decline/Cancel

Expanded Basic Term Life and AD&D: \$1,000 increments up to \$40,000 Total coverage amount elected \$ _____ Cancel

Supplemental Term Life and AD&D: \$1,000 increments up to \$250,000 Total coverage amount elected \$ _____ Cancel

SPOUSE TERM LIFE - EOI may be required if elected coverage is above GI amount.

Spouse name	Spouse Social Security number	Spouse date of birth
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Spouse Term Life: \$ 1,000 increments up to \$50,000 Total coverage amount elected \$ _____ Cancel

CHILD TERM LIFE - EOI may be required if elected coverage is above GI amount.

Child's full name	Child's Social Security number	Child's date of birth

Child Term Life: \$1,000 increments up to \$50,000 (amount per child) Total coverage amount elected \$ _____ Cancel

If more room is needed add another sheet of paper.

BENEFICIARY INFORMATION - (Employee is the beneficiary of any dependent coverage)

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security #	Relationship	Share %

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security #	Relationship	Share %

Total = 100%

AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage. I understand that premium for cancelled coverage is due through the end of the month in which Minnesota Life receives my signed request.

Employee signature X	Date signed
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