Voluntary Group Term Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
Group Customer Service • 400 Robert Street North, St. Paul, MN 55101-2098

EMPLOYER NAME: State of Tennessee **POLICY NUMBER: 34175**

Reason for Enrollment: ☐ New Hire ☐ Family Status Change Date of Family Status Change _____ ☐ Annual Enrollment

1. Complete sections A, B, and F.
2. If you are electing coverage on your dependents, complete sections C, D, and/or E.

If you have questions, please contact Minnesota Life at 1-866-881-0631.

A. EMPLOYEE INFORMATION

First name Middle initial Last name

Email address

Street address	City	State	Zip code

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

Total amount of insurance requested ($5,000 increments to a maximum of 7 times base annual salary or $500,000, whichever is less. Up to 5 times base annual salary is guaranteed if elected within 30 days of hire. Electing 6x or 7x base salary will require you to complete the separate Evidence of Insurability form.)

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B. EMPLOYEE BENEFICIARY INFORMATION

Primary beneficiary(ies) designation (include full name and address) *The person or persons named will receive the benefits.*	Relationship	Share % (Primary beneficiaries must total 100%)

Contingent beneficiary(ies) designation (include full name and address) *If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s).*	Relationship	Share % (Contingent beneficiaries must total 100%)

PLEASE NOTE: If you do not designate a beneficiary, any death proceeds would be paid out at State of TN's plan default:

1. Spouse 2. Child(ren) 3. Parent(s) 4. Estate of Insured

C. SPOUSE INFORMATION

First name Middle initial Last name

Email address

Has your spouse been hospitalized, advised to seek medical treatment, or received disability benefits in the past six months? ☐ Yes ☐ No

Date of birth	Social Security number	Gender
		☐ Male ☐ Female

Total amount of spouse voluntary term life insurance requested

☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 (Spouse under age 55 only)
☐ $25,000 (Spouse under age 55 only) ☐ $30,000 (Spouse under age 55 only)

D. SPOUSE BENEFICIARY DESIGNATION (if no beneficiary is designated, employee will be the default beneficiary for spouse coverage)

Primary beneficiary(ies) designation (include full name and address) *The person or persons named will receive the benefits.*	Relationship	Share % (Primary beneficiaries must total 100%)

Contingent beneficiary(ies) designation (include full name and address) *If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s).*	Relationship	Share % (Contingent beneficiaries must total 100%)

E. CHILDREN INFORMATION (Employee is the beneficiary of child coverage)

List of names and dates of birth for your eligible children:

Total amount of insurance requested

☐ $5,000 ☐ $10,000

F. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for voluntary insurance coverage.

I authorize the State Group Insurance Plan to release to Minnesota Life on behalf of myself and all family members information (name, address, Social Security number, age, gender, salary, enrollment effective/termination dates) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The State Group Insurance Plan will not condition treatment, payment, or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee signature	Daytime phone number	Evening phone number	Date signed
X			