

# Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company  
400 Robert Street North • 18-3789 • St. Paul, Minnesota 55101-2098

**MINNESOTA LIFE**

**EMPLOYER NAME:**

**POLICY NUMBER:**

1. Return completed and signed form to
2. Please complete the Group Life Evidence of Insurability form for coverage that is not guaranteed.

## A. EMPLOYEE INFORMATION

First name		Middle initial	Last name	
Email address				
Street address		City	State	Zip code
Will the insurance applied for replace or change an existing policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of birth		Date of employment	Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

## B. SPOUSE INFORMATION

First name		Middle initial	Last name	
Email address			Marriage date	
Will the insurance applied for replace or change an existing policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of birth	Social Security number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

## C. CHILDREN INFORMATION

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

## D. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for 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 <b>X</b>	Daytime telephone number	Evening telephone number	Date signed
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## FOR HOME OFFICE USE ONLY:

Agent/broker/registered representative		Agent's Florida license identification number	
Agent's signature <b>X</b>	AGENT: To the best of my knowledge and belief, will the insurance applied for replace or change an existing policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	