Life and AD&D and Disability Income Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor Independent School District #279			Group/Plan Number 63245-7	Account Number/Location 1
Class/Occupation **Clerical**	Date of Hire	Annual Salary	Employment Status: ☐ Active Full-Time ☐ Active Part-Time	☐ Retired ☐ MN Life Continuation
This change is due to: (check all that apply) ___Change in Coverage Amount ___Other: _______________ ___ Initial Eligibility Following Hire ___Late Entrant* ___ MN Life Continuation: Qualifying Event # _____ *(#1=Employment Termination, #2=Reduction in Hours)*				Effective Date of Coverage or Change:

Employee Information

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*			Telephone Work ( ) Home ( )	

Disability Income Coverage

Monthly Income Benefits (LTD)	☒ Elect Coverage *(Note: LTD coverage is employer provided.)*

Employee Life Insurance

Basic Life and Basic AD&D	☒ Employee Only—Elect Coverage *(Note: Basic Life insurance is employer provided.)*
Supplemental Life and AD&D	Guaranteed Issue (GI) Limit = $35,000, option 2. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. At each annual enrollment, if you have current supplemental life coverage you can elect to increase supplemental life coverage (total coverage not to exceed the GI Limit) without evidence of insurability. Please note that the total amount of Supplemental Life cannot exceed 3 times your annual salary.
Supplemental Life and AD&D Election	______Option 1 = $25,000; _________Option 2 = $35,000 ______Waive

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)*	Address	Phone Number	Relationship to Employee	Benefit % *(MUST total 100%)*

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW τ

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I understand that evidence of insurability may be required for coverage to become effective.
- I also understand that the group policy may include a pre-existing condition provision that may limit or exclude coverage for a period of time if I have a pre-existing condition as defined on the date my coverage becomes effective. The group certificate or other material made available with this enrollment form includes a description of the group policy's pre-existing condition limitation or exclusion, if any.

Employee's Signature	Date Signed / /