

Life and AD&D 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 Custodians	Date of Hire (mm/dd/yyyy)	Annual Salary	Employment Status:	<input type="checkbox"/> Active Full-Time <input type="checkbox"/> Retired <input type="checkbox"/> Active Part-Time <input type="checkbox"/> MN Life Continuation
This change is due to: (check all that apply) <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Late Entrant* <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Other: _____ <input type="checkbox"/> MN Life Continuation: Qualifying Event # _____ (#1=Employment Termination, #2=Reduction in Hours)				Effective Date of Coverage or Change:

**A late entrant is an individual who is first enrolling for supplemental or dependent coverage after the first available opportunity.*

Employee Information

Employee Name (last, first, middle initial)		Date of Birth (mm/dd/yyyy)	Social Security #	Employee I.D. #
Employee Address (street address, city, state, zip code)			Work Phone Number	Home Phone Number
				<input type="checkbox"/> Female <input type="checkbox"/> Male

Employee Life Insurance

Basic Life and Basic AD&D	<input checked="" type="checkbox"/> Employee Only—Elect Coverage (Note: Basic Life insurance is employer provided.)
Supplemental Life and AD&D	Guaranteed Issue (GI) Limit = \$65,000, 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	<input type="checkbox"/> Option 1 = \$55,000 <input type="checkbox"/> Option 2 = \$65,000 <input type="checkbox"/> Option 3 = \$85,000 <input type="checkbox"/> Option 4 = \$100,000 <input type="checkbox"/> Waive

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

Name of Beneficiary (last name, first, middle initial)		<input checked="" type="checkbox"/> Primary	Relationship to Employee	Benefit %
Address		Date of Birth	Social Security Number	Phone Number
Name of Beneficiary (last name, first, middle initial)		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee	Benefit %
Address		Date of Birth	Social Security Number	Phone Number
Name of Beneficiary (last name, first, middle initial)		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee	Benefit %
Address		Date of Birth	Social Security Number	Phone Number

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- 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 my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed (mm/dd/yyyy)
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