

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 Food Service	Date of Hire	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"/> Change in Coverage Amount <input type="checkbox"/> Other: _____					Effective Date of Coverage or Change:
<input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Late Entrant*					
<input type="checkbox"/> MN Life Continuation: Qualifying Event # _____ (#1=Employment Termination, #2=Reduction in Hours)					

Employee Information

Employee Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> 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)	<input checked="" type="checkbox"/> Elect Coverage (Note: LTD coverage is employer provided.)
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Employee Life Insurance

Basic Life and Basic AD&D	<input checked="" type="checkbox"/> Employee Only—Elect Coverage (Note: Basic Life insurance is employer provided.)
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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 / /
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