STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM
Underwritten by Minnesota Life Insurance Company

PLEASE PRINT LEGIBLY **MINNESOTA LIFE POLICY # 33683-G**

SECTION A: Employee/Employer Information ☐ **New Enrollment** ☐ **Change**

Employee Last Name:	Employee First Name:	MI:	Social Security No.:	Birthdate (MMDDYYYY):	Sex ☐ Male ☐ Female
Employee Home Address:				Employee Home Telephone No.:	
Employer Name:				Date of Employment:	
Employer Address:				Employer Telephone No.:	

SECTION B: Waiver/Request To Cancel Coverage (Only Complete This Section To Waive Or Cancel Coverage)

☐ **Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

☐ **Cancellation of Coverage** – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN HERE ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE! _____ _____
Employee Signature **Date**

SECTION C: Type of Coverage (Check One)

ACTIVE EMPLOYEE: Life benefit amounts equal twice the amount of the employee's annual wage rounded to the next higher one thousand dollars. Minimum $30,000; Maximum $100,000. Employee and employer each pay 50% of the monthly premium.

☐ **New Employee** – applying within 31 days of employment; coverage will become effective on the first day of employment.

☐ **Late Enrollee Applicant** – applying after initial 31 days of employment; will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life Insurance Company. (**Employee Must Also Complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form*.**)

Date of Employment: _____

☐ **RETIRED EMPLOYEE:** Life benefit amounts limited to $5,000, $10,000, or $20,000. Retired Employees are not eligible for AD&D coverage. A Retired Employee should apply prior to, but no later than 31 days after, the date Active Employee coverage terminates. Retiree pays 100% of the monthly premium.

Date of Retirement: _____ **COVERAGE AMOUNT REQUESTED:** ☐ **$5,000** ☐ **$10,000** ☐ **$20,000**

☐ **DISABLED EMPLOYEE:** Life benefit amount is equal to employee's current benefit level at the time coverage ceases as an Active Employee. Disabled Employee must apply no later than 31 days from the date Active Employee coverage terminates. Minnesota Life Insurance Company is solely responsible for evaluating applications for coverage continuation. Premium is waived after 1st 9 months.

(Employee Must Also Complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

Employee Last Name	Employee First Name	MI	Social Security Number	Daytime Telephone # ( )

SECTION D: Beneficiary Information

If more than one **Primary Beneficiary** is named, the Primary Beneficiaries shall share equally unless otherwise indicated below. Likewise, if more than one **Contingent Beneficiary** is named, the Contingent Beneficiaries shall share equally unless otherwise indicated below. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc., in the **Percentage of Benefit** block, and list each in the order of precedence. **If beneficiary shares are not equal, please ensure the percentage of benefits = 100%, USING WHOLE NUMBERS ONLY (ex: 33% + 33% + 34% = 100%).**

1. Beneficiary Name, Address, and Telephone #:			☑ **Primary Beneficiary**
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:

2. Beneficiary Name, Address, and Telephone #:			☐ **Primary Beneficiary** *or* ☐ **Contingent Beneficiary*** **PLEASE CHECK DESIRED BENEFICIARY TYPE**
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:

3. Beneficiary Name, Address, and Telephone #:			☐ **Primary Beneficiary** *or* ☐ **Contingent Beneficiary*** **PLEASE CHECK DESIRED BENEFICIARY TYPE**
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:

4. Beneficiary Name, Address, and Telephone #:			☐ **Primary Beneficiary** *or* ☐ **Contingent Beneficiary*** **PLEASE CHECK DESIRED BENEFICIARY TYPE**
Relationship to Insured:	Social Security Number:	Date of Birth:	Percentage of Benefit:

***NOTE: Contingent Beneficiaries will only receive proceeds if <u>all Primary Beneficiaries</u> have predeceased the Insured.**

SECTION E: Authorization and Certification

I apply for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life Insurance Company. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Group Policy #33683-G and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan. I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event. I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life Insurance Company as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan. Subject to the terms of Minnesota Life Group Policy #33683-G, I request that any sum becoming payable by reason of my death be payable to the beneficiary(ies) listed above. It is my understanding that this designation shall operate so as to revoke all designations of beneficiary previously made by me under this Policy.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature (Required)	**Date**

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	**REQUESTED EFFECTIVE DATE:**	**GROUP NUMBER:**	**INFORMATION VERIFIED: (INITIAL AND DATE)**