Public School Employees
Group Term Life Enrollment and Service Request

Minnesota Life Insurance Company - A Securian Company
Group Customer Service
400 Robert Street North ● St. Paul, MN 55101-2098 ● Phone 1-888-826-2734 ● Fax 651-665-4827

MINNESOTA LIFE

EMPLOYER NAME: ARBenefits Life **POLICY NUMBER: 33432/33553**

School District Name: _____

Reason for Enrollment:

☐ New Hire ☐ Rehire ☐ Family Status Change*

☐ Summer/Fall Transfer * ☐ Marriage/Divorce Date _____ ☐ Birth/Adoption Date _____

☐ Annual Open Enrollment Please provide a copy of the marriage license/divorce decree/birth certificate

A. EMPLOYEE INFORMATION

Employee's full name (please print)

Date of birth	Social Security number	Contract #	Hire Date/Rehire Date

Mailing address	Email address

B. INSURANCE AMOUNT - To elect coverage please check appropriate boxes

Basic Term Life* and AD&D: ☐ $10,000 ☐ Decline/cancel

***Must elect Basic Term Life to elect any additional coverage.**

Expanded Basic Term Life and AD&D: ☐ $_____ ($1,000 increments to $40,000) ☐ Decline/cancel

Supplemental Term Life and AD&D: ☐ $_____ ($1,000 increments to $250,000) ☐ Decline/cancel

Spouse Term Life: ☐ $_____ ($1,000 increments to $50,000) ☐ Decline/cancel

Child Term Life (per child): ☐ $_____ ($1,000 increments to $50,000) ☐ Decline/cancel

For Spouse and Child Term Life, Evidence of Insurability may be required if elected coverage is above guaranteed issue amounts.

C. DEPENDENT INFORMATION (Only required if electing Dependent coverage)

Spouse name	Spouse Social Security number	Spouse date of birth

Children's names	Children's Social Security number	Children's dates of birth

D. BENEFICIARY INFORMATION (EMPLOYEE IS THE BENEFICIARY OF ANY DEPENDENT COVERAGE)

Primary beneficiary name(s) and address *(If more room is needed, attach a separate sheet of paper.)*	Relationship	Share % (must total 100%)

Contingent beneficiary name(s) and address *(Contingent beneficiaries collect only if all primary beneficiaries predecease the insured.)*	Relationship	Share % (must total 100%)

E. SPECIAL REQUESTS

Include any comments or special requests here.

F. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage. I understand that premium for cancelled coverage is due through the end of the month in which Minnesota Life receives my signed request.

Employee signature	Daytime phone number	Date signed
X		