MINNESOTA LIFE

EMPLOYER NAME: Owens State Community College

LIFE POLICY NUMBER: 34569 AD&D POLICY NUMBER: 34573

- 1. Please complete Group Life Evidence of Insurability for coverage that is not guaranteed.
- 2. Return completed and signed form to your Benefits Office.

A. EMPLOYEE INFORMATION				
First Name Middle Initial Last Name				
Street Address		City	State	Zip Code
Date of Birth	Social Security Number	Date of Employment	Salary	Gender
				☐ Male ☐ Female
B. BASIC LIFE				
Amount \$	Insurance Class: Effective Date:			
C. SUPPLEMENTAL LIFE				
Employee	□Increase		Grand	Effective
Current Amount \$	Amount \$	Т	otal \$	Date
	□Decrease			
Spouse	□Increase		Grand	Effective
Current Amount \$	Amount Ş □Decrease	Т	otal \$	Date
	□ Deci ease			
Child Current Amount \$	□Increase		Grand	Effective
Current Amount \$	☐Decrease	<u> </u>	otal \$	Date
D. VOLUNTARY AD&D				
Employee	□Increase		Grand	Effective
Current Amount \$	Amount \$	T	otal \$	Date
	□Decrease			
Spouse	□Increase		Grand	Effective
Current Amount \$	Amount Ş □Decrease	T	otal \$	Date
Child Current Amount \$	□Increase		Grand Total \$	Effective Date
current Amount 3	□Decrease	<u> </u>	Otal 5	Date
F CDOLLEF & CHILD INFORMA	TION			
E. SPOUSE & CHILD INFORMA Spouse First Name	Middle Init	ial Last Name		
spouse riist Name	Middle IIII	idi Last Name		
Spouse Date of Birth Is your spouse plea an ampleyee sourced under this plea? Ves. No. Spouse Gender				
Spouse Date of Birth	Is your spouse also an emp	oyee covered under the	nis plan? ☐ Yes ☐ No	□ Male □ Female
List Child(ren) Name and Date of Birth:				
List Ginagramy name and bate or birtin				
G. AUTHORIZATION				
I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental coverage.				
Employee Signature	Dayt	me Telephone Number	Evening Telephone Number	Date Signed