Group Life Insurance Enrollment Worksheet

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 Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____
Spouse Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____
Child Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____

D. VOLUNTARY AD&D

Employee Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____
Spouse Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____
Child Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____

E. SPOUSE & CHILD INFORMATION

Spouse First Name | Middle Initial | Last Name

Spouse Date of Birth	Is your spouse also an employee covered under this plan? ☐ Yes ☐ No	Spouse Gender ☐ Male ☐ Female

List Child(ren) Name and Date of Birth:

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	Daytime Telephone Number	Evening Telephone Number	Date Signed