

# MINNESOTA LIFE

# GROUP LIFE INSURANCE EMPLOYEE AND DEPENDENT ENROLLMENT

Minnesota Life Insurance Company • B2-4930 • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**Return Completed Application To: OCHS, Inc. 400 Robert Street North, Suite 1880 St. Paul, MN 55101**

## EMPLOYEE INFORMATION

EMPLOYER				POLICY NUMBER	UNIT
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)			DATE OF EMPLOYMENT	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
DATE OF BIRTH (Mo, Day, Yr)	BENEFICIARY	RELATIONSHIP	MARRIAGE DATE	EMAIL ADDRESS	
HEIGHT	WEIGHT	BASIC SALARY \$	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OCCUPATION	
SPOUSE NAME (LAST, FIRST, MIDDLE INITIAL)				SPOUSE SOCIAL SECURITY NUMBER	
DATE OF BIRTH (MONTH, DAY, YEAR)	HEIGHT	WEIGHT	EMAIL ADDRESS		

Basic Employee Life Insurance	Insurance Class: _____	Amount: _____	Eff. Date: _____
	Present Amount	Increase/Decrease	Grand Total
Employee Additional Life Insurance	\$ _____	\$ _____	\$ _____
Spouse Life Insurance	\$ _____	\$ _____	\$ _____
Dependent Life Insurance	\$ _____	\$ _____	\$ _____

## HEALTH QUESTIONS - Complete if applying for more than the guaranteed amount.

In answering the following questions, you need not disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the back of this application for a definition of "emergency medical personnel".

EMPLOYEE	SPOUSE		CHILD			
YES	NO	YES	NO	YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever been diagnosed as having AIDS, or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

If your answer to questions 1, 2 or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment on the reverse side of this form.

The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. This authorization is valid for 26 months. This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice on the reverse side of this form, and I understand that I can have copies.

I understand that premiums for all supplemental coverages will be deducted from the employee's pay.

EMPLOYEE SIGNATURE	DAYTIME TELEPHONE NUMBER	DATE SIGNED
X	( )	

98-30020

For Web Use

The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

**CONSUMER PRIVACY NOTICE**

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to an MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

**For further information about your file or your rights, you may contact:**

Group Division Underwriting  
 Minnesota Life Insurance Company  
 400 Robert Street North  
 St. Paul, Minnesota 55101-2098  
 Telephone: (800) 872-2214

**For information about the Medical Information Bureau, you may contact:**

Medical Information Bureau Information Office  
 P.O. Box 105, Essex Station  
 Boston, Massachusetts 02112  
 MIB Telephone: (866) 692-6901  
 MIB TTY: (866) 346-3642

**ADDITIONAL HEALTH INFORMATION: SPECIFY BY NAME IF INFORMATION IS FOR APPLICANT, SPOUSE OR CHILD.**

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

**COMPLETE FOR DEPENDENT CHILD(REN) COVERAGE - List Oldest to Youngest**

CHILD'S NAME	CHILD'S BIRTHDATE	SOCIAL SECURITY NUMBER	CHILD'S NAME	CHILD'S BIRTHDATE	SOCIAL SECURITY NUMBER

**FOR HOME OFFICE USE ONLY:**

Employee		Spouse/Child		Child	
CURRENT IN FORCE	U/W APPLIED FOR	CURRENT IN FORCE	U/W APPLIED FOR	CURRENT IN FORCE	U/W APPLIED FOR
\$	\$	\$	\$	\$	\$
<input type="checkbox"/> APPR'D	<input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.	<input type="checkbox"/> APPR'D	<input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.	<input type="checkbox"/> APPR'D	<input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.
BY				DATE	