

Group Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: Florida Conference of the United Methodist Church **POLICY NUMBER: 33262/33263**

Church name	GCFA #	District		
Church street address	City	State	Zip code	Church telephone number

A. EMPLOYEE INFORMATION

First name Middle initial Last name

Email address

Street address City State Zip code

Are you actively working at your employer's normal place of business at least 30 hours per week? Yes No

Will the insurance applied for replace or change an existing policy? Yes No

Date of birth Social Security number Date of employment Gender
 Male Female

Total amount of life insurance requested

No election \$50,000 \$100,000 \$150,000 \$200,000 \$250,000

Total amount of accidental death & dismemberment (AD&D) insurance requested employee only employee and family

No election \$50,000 \$100,000 \$150,000 \$200,000 \$250,000

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

Primary beneficiary name(s) and address	Relationship	Social Security number(s)	Share % (must total 100%)
Contingent beneficiary name(s) and address	Relationship	Social Security number(s)	Share % (must total 100%)

C. SPOUSE INFORMATION

First name Middle initial Last name

Email address

Will the insurance applied for replace or change an existing policy? Yes No

Date of birth Social Security number Gender
 Male Female

Total amount of life insurance requested

No election \$25,000 \$50,000 \$75,000 \$100,000

D. CHILDREN INFORMATION (List of names and dates of birth for your eligible children)

Total amount of child life insurance requested
 No election \$5,000 \$10,000

E. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for supplemental insurance coverage.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Employee signature Daytime telephone number Evening telephone number Date signed
X

FOR HOME OFFICE USE

Agent/broker/registered representative Agent's Florida license identification number

Agent's signature AGENT: To the best of my knowledge and belief, will the insurance applied for replace or change an existing policy? Yes No Date
X