Group Life Insurance Enrollment

Minnesota Life Insurance Company, a Securian Financial Group affiliate
400 Robert Street North • B1-3102 • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: State of Florida **POLICY NUMBER: 33503**

1. Complete all sections of this form and submit it to the People First Service Center at P.O. Box 6830, Tallahassee, FL 32314.
2. If you are electing coverage that is not guaranteed, complete an Evidence of Insurability form and mail it to Minnesota Life at 400 Robert Street North, B2-3102, St. Paul, MN 55101-2098.

A. EMPLOYEE INFORMATION

First name | Middle initial | Last name

Email address

Street address	City	State	Zip code

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

Select your type of enrollment

☐ New hire ☐ Qualifying status change ☐ Open enrollment

Remember to designate/update your beneficiary(ies)

B. BASIC TERM LIFE AND AD&D

Benefit amounts:

Class 1 - Career service, University Support, etc. = 1.5x base annual earnings
Class 2 - SMS, SES, Legislature, etc. = 2x base annual earnings
Class 3 - Active Senators and Representatives = $150.000
Class 4 - Retirees = Option 1: $2,500 for $7.41 or Option 2: $10,000 for $29.65

Check the appropriate box to indicate your coverage selection (plan maximum is $500,000)

☐ Enroll Basic Term Life/AD&D ☐ Waive Basic Term Life/AD&D ☐ Cancel Basic Term Life/AD&D

☐ Retiree Option 1 ☐ Retiree Option 2

C. OPTIONAL TERM LIFE AND AD&D

Check the appropriate box to indicate your coverage selection (plan maximum is $500,000)

☐ 1x base annual earnings ☐ 2x base annual earnings ☐ 3x base annual earnings

☐ 4x base annual earnings ☐ 5x base annual earnings

☐ Waive Optional Term Life/AD&D ☐ Cancel Optional Term Life/AD&D

Note:

- This coverage is in addition to Basic Term Life Insurance.
- You must be enrolled in Basic Term Life Insurance to enroll in Optional Term Life coverage.
- Coverage is available to active employees on a post-tax basis.
- Retired employees are not eligible for enrollment in Optional Term Life Insurance.

D. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for employee-paid 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?	Date
X	☐ Yes ☐ No	