

Minnesota Life Insurance Company - A Securian Company
 260 Peachtree Street NW • Suite 1203 • Atlanta, Georgia 30303

EMPLOYEE INFORMATION

First name	Middle initial	Last name	Social Security number	
Street address		City	State	Zip code
Date of birth	Email address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Total amount of employee life insurance requested <input type="checkbox"/> 1x salary <input type="checkbox"/> 2x salary <input type="checkbox"/> 3x salary <input type="checkbox"/> 4x salary <input type="checkbox"/> 5x salary <input type="checkbox"/> 6x salary <input type="checkbox"/> 7x salary <input type="checkbox"/> 8x salary <input type="checkbox"/> 9x salary				
Agency/department				

CHILDREN INFORMATION - (list names and dates of birth for your eligible children)

	Total amount of child life insurance requested
	<input type="checkbox"/> \$3,000 <input type="checkbox"/> \$6,000
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000
	<input type="checkbox"/> \$20,000

HEALTH QUESTIONS - (must be answered for coverage that is not guaranteed)

EMPLOYEE	CHILDREN	Employee		
		Height Weight		
YES	NO	YES	NO	
<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"/>	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"/>	3. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (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 you answer yes to any question, give details including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment in the Additional Health Information Section on the second page or on a separate sheet of paper.

AUTHORIZATION

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. If I do not revoke this authorization, it will be valid for 24 months from the date I sign it. A photocopy shall be as valid as the original. I have read this Authorization and the Consumer Privacy Notice on the second page and I understand that I can have copies.

Employee signature X	Daytime telephone number	Evening telephone number	Date signed
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