Group Term Life Insurance Enrollment

Minnesota Life Insurance Company - a Securian Financial company
Group Customer Service • 400 Robert Street North, St. Paul, MN 55101-2098
Fax 651-665-4827

EMPLOYER NAME: Los Angeles Unified School District **POLICY NUMBER: 34777**

EMPLOYEE INFORMATION

Name (first, middle initial, last)	Date of birth	Social Security number

Address (street, city, state, zip)

Email address

Date of employment	Annual salary	Payroll frequency	Sex
		☐ 10 month ☐ 12 month	☐ Male ☐ Female

Are you working at your employer's normal place of business at least 15 hours per week?
☐ Yes ☐ No

Total amount of insurance requested (elect up to 5x annual earnings to a plan maximum of $500,000)
☐ .5x ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x annual salary

If request is due to a family status change, indicate date of change

BENEFICIARY INFORMATION (Employee is the beneficiary of any dependent coverage)

Primary beneficiary(ies) – The person(s) named will receive the proceeds

Beneficiary full name	Date of birth	Address and phone number	Social Security number	Relationship	Share % (must total 100%)
					%
					%
					%

Contingent beneficiary(ies) – If the primary beneficiary(ies) is no longer living, the benefit is paid to the following person(s)

Beneficiary full name	Date of birth	Address and phone number	Social Security number	Relationship	Share % (must total 100%)
					%
					%
					%

SPOUSE INFORMATION (only complete if electing coverage)

Name (first, middle initial, last)	Date of birth	Social Security number

Address (street, city, state, zip; check here if same as above ☐)

Email address	Sex
	☐ Male ☐ Female

Total amount of insurance requested (not to exceed employee's supplemental life amount of coverage)
☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000

CHILDREN INFORMATION (only complete if electing coverage)

Name (first, middle initial, last)	Date of birth	Total amount of insurance requested
		☐ $5,000 ☐ $10,000

AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for this insurance coverage. **For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

Employee signature	Phone number	Date signed
X		