Group Universal Life Employee Application

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: San Bernardino County **POLICY NUMBER: 50227**

EMPLOYEE INFORMATION (employee is the owner of the insurance unless otherwise requested)

Name (first, middle initial, last)	Email address

Address (street, city, state, zip)

Annual benefit salary base	Employee ID	Exempt group ☐ A ☐ B ☐ C ☐ D	Date of birth
Social Security number	Date of employment		Sex ☐ Male ☐ Female

On the date you sign this application, are you working at your employer's normal place of business at least 60 hours per pay period?
☐ Yes ☐ No

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%)
					%
					%
					%

INSURANCE INFORMATION

If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form.

Amount of automatic coverage

☐ County-paid coverage only (Applicable to Exempt Group A, Elected Official, and Exempt Group B only)
Please note a portion of your total coverage may be paid for by San Bernardino County.

Amount of elected coverage (if you are in Benefit Group C or D you must elect a minimum of 1x salary to be eligible for coverage)

☐ 1x ☐ 2x ☐ 3x annual salary

Amount of biweekly contribution to the cash accumulation account

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

AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for Group Universal Life 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		