State of Illinois Policy Number 32491-G
Group Life Insurance Statement of Health

MAIL TO:
Minnesota Life Insurance Company - A Securian Company
Springfield Branch Office • 1 North Old Capitol Plaza, Suite, 305 • Springfield, Illinois 62701

MINNESOTA LIFE

EMPLOYEE INFORMATION

First name	Middle initial	Last name	Date of birth	Social Security number	
Street address			City	State	Zip code

Date employed

Member status (check all that apply)
☐ Actively working ☐ Full time ☐ Part time ☐ Annuitant ☐ Immediate ☐ Deferred ☐ Survivor

Height	Weight	Occupation	Sex ☐ Male ☐ Female

TOTAL INSURANCE DESIRED - Check the boxes which indicate your total coverage level desired.

Optional Life (member-paid)*

☐ 1x salary ☐ 3x salary ☐ 5x salary ☐ 7x salary
☐ 2x salary ☐ 4x salary ☐ 6x salary ☐ 8x salary

* Annuitants age 60 and over are not eligible for 5-8x salary.

Dependent Life (member-paid)

☐ Spouse life coverage equal to $10,000*

* Spouses of annuitants age 60 and over receive $5,000 coverage.

☐ Child life coverage equal to $10,000

☐ Adding another child

SPOUSE INFORMATION - Complete only if applying for spouse coverage.

SPOUSE

First name	Middle initial	Last name	Social Security number
Date of birth	Height	Weight	Sex ☐ Male ☐ Female

DEPENDENT CHILD(REN) INFORMATION - Complete only if applying for dependent coverage.

Child's Name	Sex	Birth Date	Social Security Number	If Age 19+ / Full Time Student
	M/F			☐ Yes ☐ No
	M/F			☐ Yes ☐ No
	M/F			☐ Yes ☐ No
	M/F			☐ Yes ☐ No
	M/F			☐ Yes ☐ No

HEALTH QUESTIONS - Complete only if changing coverage.

EMPLOYEE YES	EMPLOYEE NO	SPOUSE YES	SPOUSE NO	CHILD(REN) YES	CHILD(REN) NO	
☐	☐	☐	☐	☐	☐	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
☐	☐	☐	☐	☐	☐	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?
☐	☐	☐	☐	☐	☐	3. Have you ever been treated or diagnosed by a physician as having 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 your answer to questions 1, 2 or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment on the reverse side of this form.

NOTE: EMPLOYEE / APPLICANT MUST SIGN AND DATE THE REVERSE SIDE OF THIS FORM

FOR HOME OFFICE USE ONLY:

Employee ☐ New hire ☐ Benefit choice enrollment ☐ Change of status

Optional in force	Annual base salary	Agency name	Date
☐ 1x ☐ 3x ☐ 5x ☐ 7x ☐ NONE ☐ 2x ☐ 4x ☐ 6x ☐ 8x	$		

Spouse coverage in force	Child coverage in force	GIR name	Organizational processing code
☐ Yes ☐ No	☐ Yes ☐ No		

Employee		Spouse		Child	
☐ Appr'd ☐ Decl. ☐ Incom.		☐ Appr'd ☐ Decl. ☐ Incom.		☐ Appr'd ☐ Decl. ☐ Incom.	
By	Date	By	Date	By	Date

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

For further information about your file or your rights, you may contact:

Group Division Underwriting
Minnesota Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: (800) 872-2214

For information about the MIB, you may contact:

MIB
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
MIB Telephone: (866) 692-6901
MIB TTY: (866) 346-3642
Website: www.mib.com

ADDITIONAL HEALTH INFORMATION: SPECIFY BY NAME IF INFORMATION IS FOR APPLICANT, SPOUSE OR CHILD.

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT
Employee				
Spouse				
Child(ren)				

The answers provided on this application are representations of each 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. This authorization is valid for 26 months unless withdrawn by me in writing. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice above, and I understand that I can have copies.

I understand that premiums for all supplemental coverages will be deducted from the employee's pay.

Employee signature	Daytime telephone number	Evening telephone number	Date signed
X	( )	( )	
Spouse signature	Daytime telephone number	Evening telephone number	Date signed
X	( )	( )	