MINNESOTA LIFE

STATE OF ILLINOIS POLICY NUMBER 32491-G
GROUP LIFE INSURANCE
STATEMENT OF HEALTH

Minnesota Life Insurance Company ● Springfield Branch Office ● 1 North Old Capitol Plaza, Suite 305 ● Springfield, Illinois 62701

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
			☐ M ☐ F

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/DEPENDENT INFORMATION - Complete only if changing coverage.

SPOUSE

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	HEIGHT	WEIGHT	SEX
			☐ M ☐ F

DEPENDENT CHILD(REN) COVERAGE - List Oldest to Youngest.

CHILD'S NAME	SEX	BIRTHDATE	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
	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

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CONSUMER PRIVACY NOTICE

In addition to the information requested on this application, the Company may ask for the following: an insurance medical exam or laboratory tests; medical records from your physician, hospital, or your insurance company; an investigative consumer report; a report from the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The Company or its reinsurer may make a brief report of this information to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

The Company may also send information about you to the following persons or organizations without your permission: to insurance organizations, for statistical studies, without identifying you; to a government agency involved in regulation of insurance; to your physician (the results of your insurance exam).

You have certain rights in connection with this insurance application. You have the right to: find out what personal information is contained in the Company or MIB files; correct or amend information in the Company or MIB files; know the specific reasons why coverage is not issued.

At your request, the Company will explain in writing how you can exercise your right to learn what is in your file, how to correct or amend it, or how to find out why coverage is not issued.

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
(800) 872-2214

For information about the Medical Information Bureau, you may contact:

Medical Information Bureau Information Office
P.O. Box 105, Essex Station
Boston, Massachusetts 02112
(MIB telephone number: (617) 426-3660)

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	( )	( )	