



Group Universal Life Employee Application

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • B2-4256 • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: State of Delaware

POLICY NUMBER: 50166

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

First name	Middle initial	Last name	Date of birth	Social Security number
Street address	City		State	Zip code
Email address (optional)			Date of employment	
Occupation	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	

If you are part-time, are you actively working at your employer's normal place of business at least 15 hours per week? Yes No

If you are full-time, are you actively working at your employer's normal place of business at least 30 hours per week? Yes No

BENEFICIARY DESIGNATION

Primary beneficiary's name	Relationship	Share % (must total 100%)
Contingent beneficiary's name	Relationship	Share % (must total 100%)

INSURANCE INFORMATION

If applying for more than the guaranteed issue amount, you must complete the **Health Questions** on the second page.

Choose amount of group universal life insurance (multiples of salary)

1x salary 2x salary 3x salary 4x salary 5x salary 6x salary

Contribution to the cash accumulation account net per pay amount (must be in whole dollars with a minimum of \$5.00 per pay)

\$ Waive

Dependent term life insurance (please choose option and complete information below)

\$10,000 spouse \$6,000 child(ren) Waive

DEPENDENT TERM LIFE INFORMATION

Please provide the following information for your eligible spouse and/or child(ren).

Spouse's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth
Child's name	Date of birth

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 an 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, rights 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 Medical Information Bureau, contact:

Medical Information Bureau Information Office
 P.O. Box 105, Essex Station
 Boston, Massachusetts 02112
 MIB Telephone: (866) 692-6901
 MIB TTY: (866) 346-3642

HEALTH QUESTIONS

Please complete this section if you are applying for coverage above your existing or guaranteed coverage level.

Employee		Spouse		Child		
YES	NO	YES	NO	YES	NO	
<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"/>	(2) During the past ten years, 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"/>	(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 particulars 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 below or on a separate sheet of paper.

ADDITIONAL HEALTH INFORMATION

DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

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. This authorization is valid for 26 months. A photocopy shall be as valid as the original. I have read this and the Consumer Privacy Notice and I understand that I can have copies.

Employee signaure X	Daytime telephone number	Evening telephone number	Date signed
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