THE OHIO STATE UNIVERSITY

Affiliated Group Voluntary Group Term Life Insurance Enrollment

Minnesota Life Insurance Company, a Securian Financial Group affiliate
400 Robert Street North • St. Paul, MN 55101-2098

EMPLOYER NAME: The Ohio State University
POLICY NUMBER: 33909
OSU

1. If you are electing coverage on your dependents, complete section 1 and/or section 2 or 3 (as applicable) and section 4.
2. Please return completed form to your human resource contact.
3. Visit **hr.osu.edu/oe** for additional program information, including eligibility, and rates.

SECTION 1: EMPLOYEE INFORMATION

First Name M.I. Last Name Social Security # (required)

Email Address Daytime Phone Number

Street Address City State Zip Code

Date of Birth Date of Employment Gender: ☐ Male ☐ Female

Reason for completing form: ☐ Open Enrollment (Return by November 15, 2022)

SECTION 2: SPOUSE

First Name M.I. Last Name

Email Address Daytime Phone Number

Date of Birth Gender: ☐ Male ☐ Female

Has your spouse used tobacco in any form during the past 12 months or is your spouse currently using nicotine in any form? ☐ Yes ☐ No

Life insurance amount requested ($25,000 increments, from $25,000 to $300,000. **NOTE:** Completion of EOI is required for coverage exceeding $25,000): $ _____

SECTION 3: CHILDREN INFORMATION (Children are eligible from live birth to age 26)

Life insurance amount requested: ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

SECTION 4: AUTHORIZATION

I have read and understand the materials describing the terms and conditions of the Voluntary Group Term Life Insurance program, including the Group Term LifeInsurance policy, and agree to be bound by such terms and conditions. I certify that the information I have provided in this Enrollment Form is complete and correct. Iauthorize my employer to deduct from my pay, on an after-tax basis, the premiums described in the benefit plan rates online at **hr.osu.edu/benefits/rates** that arenecessary to pay for the life insurance coverage that I have elected above. I understand that this authorization to deduct premiums directly from my pay will remain ineffect until I cancel my enrollment or transfer to an ineligible appointment. I understand and agree that in the event my pay is not sufficient to pay the premiums for this benefit, or if I go on an unpaid leave of absence, I will be billed directly for these premiums. I agree to pay those premiums promptly and in full. I understand that, if premiums are not paid in full, the benefit will be terminated for lack of payment and I will be responsible for premiums missed prior to my coverage termination date. I understand that coverage requiring evidence of insurability (EOI) must be approved by Securian Financial. If EOI is approved by Securian Financial, any additional coverage elected will be effective as of the approval date designated by Securian Financial. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee Signature Date

Daytime Phone Number Evening Phone Number