

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Reason for completing form: Open Enrollment (Return by November 15, 2025.)

SECTION 2: SPOUSE

First Name	M.I.	Last Name
Email Address		Daytime Phone Number
Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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 to \$300,000). \$_____. NOTE: Completion of EOI is required for amounts greater than \$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 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. I authorize my employer to deduct from my pay, on an after-tax basis, the premiums that are necessary 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 in effect 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 I may be responsible for these premiums. 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 per the plan details. 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 _____