Group Universal Life Employee Application

Securian Life Insurance Company
Group Customer Service • 400 Robert Street North, St. Paul, MN 55101-2098
Fax 651-665-4827

EMPLOYER NAME: University of Rochester **POLICY NUMBER: 75033**

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

Name (first, middle initial, last)	Email address

Address (street, city, state, zip)

Annual salary	Payroll frequency	Date of birth	Social Security number

Date of employment	Occupation	Sex
		☐ Male ☐ Female

Have you used tobacco in any form during the past twelve months or are you currently using nicotine in any form?
☐ Yes ☐ No

On the date you sign this application, are you actively working at your employer's normal place of business at least 17.5 hours per week?
☐ Yes ☐ No

BENEFICIARY INFORMATION (Employee is the beneficiary of any dependent coverage)

Primary beneficiary(ies) – The person(s) named will receive the proceeds

Beneficiary full name	Date of birth	Address and phone number	Social Security number	Relationship	Share % (must total 100%)
					%
					%
					%

Contingent beneficiary(ies) – If the primary beneficiary(ies) is no longer living, the benefit is paid to the following person(s)

Beneficiary full name	Date of birth	Address and phone number	Social Security number	Relationship	Share % (must total 100%)
					%
					%
					%

INSURANCE INFORMATION

If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form.

Amount of elected coverage (up to $1,500,000)
☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x ☐ 7x ☐ 8x annual salary

Amount of monthly contribution to the cash accumulation account
$

If request is due to a family status change, indicate date of change

Accidental death and dismemberment insurance requested
☐ waive ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x ☐ 7x ☐ 8x annual salary

Spouse/domestic partner term coverage
☐ waive ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

Child term coverage
☐ waive ☐ $2,500 ☐ $5,000 ☐ $10,000

If you applied for spouse/domestic partner or child term insurance, please enter the information below. Either you or your spouse/domestic partner may elect child coverage, but not both.

Spouse/domestic partner's name	Date of birth	Have you used tobacco in any form during the past twelve months or are you currently using nicotine in any form? ☐ Yes ☐ No	
Child's name	Date of birth	Child's name	Date of birth
Child's name	Date of birth	Child's name	Date of birth

AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for Group Universal Life insurance coverage. The insurance you are electing may contain a provision to waive your monthly deduction if you become disabled. There are conditions under which your insurance may terminate even if the monthly deduction has been waived.

The policy permits the group policyholder to change, reduce, restrict or terminate your rights or benefits under the policy without your consent. Such change, reduction, restriction, or termination may occur at a time when your health status has changed and may affect your ability to procure individual coverage.

This statement only applies to the accident and/or health portion of the application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Employee signature	Phone number	Date signed
X		