

# Group Universal Life Employee Application

Securian Life Insurance Company

Group Customer Service • 400 Robert Street North • St. Paul, Minnesota 55101-2098

**Benefits received under an Accelerated Benefits Policy Rider may be taxable and may affect eligibility for public assistance programs. Certificate holders should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.**

**EMPLOYER: The University of Rochester**

**POLICY NUMBER: 50191**

**INSURED'S INFORMATION** (insured is the owner of the insurance unless otherwise requested)

Employee name	Date of birth	Social Security number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address	City	State	Zip code
Email address			
Occupation	Date of employment	Annual salary	Payroll frequency

Yes  No Have you smoked during the past 12 months?  
 Yes  No Are you actively working at your employer's normal place of business at least 17.5 hours per week?

**INSURANCE INFORMATION**

If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form. The employee is the beneficiary of any dependent coverage. Guaranteed issue limits: \$600,000 new hires, \$1,000,000 open enrollment and family status change.

Amount of elected coverage (up to a maximum of \$1,500,000)

1x  2x  3x  4x  5x  6x  7x  8x annual salary

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

Amount of monthly contribution to the cash accumulation account

Waive  \$

Accidental death and dismemberment insurance requested

Waive  1x  2x  3x  4x  5x  6x  7x  8x annual salary

Spouse/domestic partner term life rider

Waive  \$10,000  \$25,000  \$50,000  \$100,000

Dependent 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	Social Security number	Has your spouse/domestic partner smoked during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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

I authorize my employer to withdraw premiums from my salary to pay for Group Universal Life insurance coverage.

Employee signature <b>X</b>	Daytime phone number	Evening phone number	Date signed
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# Beneficiary Designation

**Securian Financial Group, Inc.**  
 Minnesota Life Insurance Company  
 Securian Life Insurance Company, a New York authorized insurer  
 400 Robert Street North • St. Paul, Minnesota 55101-2098

Group Customer Service  
 Fax 651-665-4827

**EMPLOYER NAME: The University of Rochester**

**POLICY NUMBER: 50191**

Insured's name (last, first, middle initial)	ID (last 4 of Social Security number)
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Address (street, city, state, zip)

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address
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This beneficiary designation applies to all eligible coverages.

**INSTRUCTIONS:**

1. Clearly print or type the information below.
2. **Sign and date the completed form.**
3. Return to Securian at the address above by mail or fax.

**CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS**

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

***The same person cannot be named as a primary and a contingent beneficiary.***

**PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit**

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

**Total = 100%**

**CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)**

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

**Total = 100%**

**SIGNATURE REQUIRED**

Policyowner's signature <b>X</b>	Date
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