MINNESOTA LIFE

ENROLLMENT APPLICATION FOR VRS OPTIONAL GROUP LIFE INSURANCE

Minnesota Life Insurance Company Richmond Branch Office P.O. Box 1193 Richmond VA 23218-1193

Employer Code (5 digits)	Employer Name	Employee's Annual Salary $

1 - EMPLOYEE INFORMATION

Social Security Number	Employee Name (LAST, FIRST, MIDDLE INITIAL)

Street Address	City	State	Zip Code

Sex		Age	Date of Birth (MO/DAY/YR.)	Employment Date (MO./DAY/YR.)
☐ Male ☐ Female	☐ Married ☐ Single			

2 - ELECTION OF INSURANCE AMOUNTS

I wish to insure myself ☐ and ☐ my spouse and ☐ my child(ren).

Sign and date section 4, Payroll Deduction Authorization. (If you do not elect to be insured under the VRS Optional Plan you must complete section 5 below.)

OPTIONAL INSURANCE AMOUNTS

Option	Employee	Spouse	Child(ren)
☐1	1 X Salary	.5 X Salary	$ 5,000
☐2	2 X Salary	1.0 X Salary	$ 5,000
☐3	3 X Salary	1.5 X Salary	$ 10,000
☐4	4 X Salary	2.0 X Salary	$ 15,000

If the option you elected will provide insurance of $250,000 or higher, you must complete an Evidence of Insurability form (EOI). You spouse must also complete an EOI form if you elected options 2, 3 or 4. Optional amounts of insurance in excess of $500,000 for an employee and $250,000 for a spouse are not provided. If you and your spouse are insured as employees under the Basic VRS Group Life Insurance Plan neither of you is eligible for coverage as a spouse. If you do not apply when you are first eligible to do so, or within 31 days immediately thereafter, you must complete and EOI for yourself and eligible dependents you subsequently elect to insure.

3 - DEPENDENT INFORMATION

See reverse side for definition of Eligible Dependents (eligibility must be verified by Employer's Representative.)

How many children do you have who are less then 21 years of age? ______________

How many children do you have who are age 21 to 25 and who are currently full-time students? ______________

List information about your spouse and **youngest** child below:

Name: First	MI	Last	Relationship	Sex M or F	Social Security Number	Date of Birth Month Day Year
			Your Spouse			
			Youngest Child			

4 - PAYROLL DEDUCTION AUTHORIZATION

I hereby authorize my Employer to deduct from my compensation the amount necessary to provide the insurance amounts indicated above. I understand that the deduction amount will change as my age and annual salary change.

Signature X	Date Signed

5 - WAIVER OF COVERAGE

I **DO NOT** wish to enroll for myself or for my eligible dependents in the VRS Optional Insurance Plan. I understand that once coverage is waived, I will have to furnish evidence of insurability for myself and eligible dependents if I wish to become insured at a later date.

Signature X	Date Signed

6 - STATEMENT BY EMPLOYER'S REPRESENTATIVE

I certify that I believe the statements made herein are true and accurate, as disclosed by the records of this office, and the Social Security Number and Annual Salary are correct as entered.

Employer's Representative X	Title	Date Signed

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EMPLOYER INFORMATION

Policyholder Name Virginia Retirement System		Policy Number 29414-G
Employee Name	Date of Birth (Mo./Day/Yr.)	Social Security Number
Employer Name		Employer Code

APPLICANT INFORMATION

Applicant Name (Last, First, Middle Initial)		Social Security Number	Relationship to Employee ☐ Self ☐ Spouse ☐ Child	
Street Address		City	State	Zip Code
Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female	Height	Weight	
Employee's Annual Salary $		Select One ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4		

HEALTH QUESTONS

Yes	No	
☐	☐	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
☐	☐	2. Have you every 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 addition?
☐	☐	3. Have you ever been diagnosed as having 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 your answer to questions 1, 2, or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment below. Use the reverse side if additional space is needed.

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 other wise 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 or the duration of a claim, whichever is less. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice on the reverse side of this form, and I understand that I or my authorized representative can have copies.

I understand that premiums for all supplemental coverages will be deducted from the employee's pay.

Applicant Signature (or employee signature for child) X	Daytime Telephone Number ( )	Date Signed