

Dependent Group Term Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

THE OHIO
STATE
UNIVERSITY

MINNESOTA LIFE

EMPLOYER NAME: The Ohio State University

**POLICY NUMBER: 33909
DGLTI**

1. Complete all sections of this form.
2. Please return completed form to the Office of Human Resources, 1590 N. High St., Suite 300, Columbus, OH 43201. Or fax to (614) 292-7813.
3. Visit hr.osu.edu/benefits for additional program information, including eligibility and information on determining need for Evidence of Insurability.

Note the employee is the beneficiary for DGLI coverage.

A. EMPLOYEE INFORMATION

First name	Middle initial	Last name	Employee ID number
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

DGLTI ELECTION

Reason For Completing Form

Date of event: ____ / ____ / ____ (return form within 31 days of event date)

Qualifying status change (please specify)

- Hired/Newly Eligible Change in Dependent Eligibility¹ Birth/Adoption/Legal Guardianship/Legal Custody¹
 Open Enrollment Marriage/Establish SSDP Coverage² Divorce/Dissolution/Termination of SSDP Coverage¹
 Other¹ (describe): _____

¹Documentation required. ²Affidavit required.

DGLTI Insurance Amount Requested

- \$5,000 Spouse/SSDP and \$2,500 Child = \$1.30 per month
 \$10,000 Spouse/SSDP and \$5,000 Child = \$2.60 per month
 \$10,000 Spouse/SSDP and \$10,000 Child = \$3.90 per month
 Waive/Cancel

B. SPOUSE/SAME-SEX DOMESTIC PARTNER INFORMATION (Affidavit of Same-Sex Domestic Partnership required)

First name	Middle initial	Last name
Email address		Daytime phone number
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

C. AUTHORIZATION

I have read and understand the materials describing the Dependent Group Term Life Insurance policy. I certify that the information I have provided in this Enrollment Form is complete and correct. I authorize my employer to make these change(s) and to deduct any premiums from my pay necessary for the life insurance coverage that I have elected above.

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 X	Daytime telephone number	Evening telephone number	Date signed
--------------------------------	--------------------------	--------------------------	-------------