



Supplemental Life Benefit Election Form Employee, Spouse and/or Dependent Coverage

Minnesota Life Insurance Company

SECTION 1: EMPLOYEE INFORMATION (Please print.)

Employee Name: _____ Employee PID Number: _____ Date of Birth: ___/___/___

Action to be Taken: Add/Increase Decrease Cancel
Amount of Supplemental Coverage Electing: 1 x's Base 2 x's Base 3 x's Base

SECTION 2: SPOUSE COVERAGE

An employee whose spouse is also employed full-time by the College may not purchase additional spouse coverage.

I elect to have spouse supplemental life insurance coverage in the amount of \$25,000.

Before spouse coverage is effective, Evidence of Insurability must be submitted and approved by the College's life insurance provider. **In the event of death, the spouse's beneficiary will be the employee.**

Spouse's Name: _____ Spouse's SSN: _____/_____/_____

Spouse's Date of Birth: ___/___/___

SECTION 3: DEPENDENT COVERAGE

I elect to have dependent supplemental life insurance coverage in the amount of \$10,000.

I understand that coverage is \$10,000 per child and Evidence of Insurability must be submitted and approved by the College's life insurance provider. **If one child in the family does not pass the Evidence of Insurability screening, none of the children in your family may be insured.** Newborns through day 13 are not covered under this provision. From day 14 to 6 months of age, coverage is 10% (\$1,000). Full coverage becomes effective at age 6 months. The \$10,000 dependent benefit is on a guaranteed issue basis if elected within 31 days of a child's birth or adoption. **In the event of a child's death, the beneficiary will be the employee.**

Dependent's Name(s): _____ SSN: _____/_____/_____ DOB: _____/_____/_____

_____ SSN: _____/_____/_____ DOB: _____/_____/_____

_____ SSN: _____/_____/_____ DOB: _____/_____/_____

_____ SSN: _____/_____/_____ DOB: _____/_____/_____

I hereby apply for supplemental insurance as indicated above. It is agreed that such change(s) shall not become effective until accepted and approved. This application for change will become part of my original application for supplemental insurance and will be subject to the terms of the policy in effect at the time of usage.

Employee Signature: _____ **Date:** _____

Florida State College at Jacksonville is a member of the Florida State College System. Florida State College at Jacksonville is not affiliated with any other public or private university or College in Florida or elsewhere.

Florida State College at Jacksonville is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award the baccalaureate degree and the associate degree. Contact the Commission on Colleges at 1866 Southern Lane, Decatur, Georgia 30033-4097, or call (404) 679-4500 for questions about the accreditation of Florida State College at Jacksonville.