

Minnesota Life Insurance Company • Springfield Branch Office • 1 North Old Capitol Plaza, Suite 305 • Springfield, Illinois 62701

**EMPLOYER INFORMATION**

POLICY HOLDER <b>State of Illinois</b>	POLICY NUMBER <b>32491-G</b>
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**EMPLOYEE INFORMATION**

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	
STREET ADDRESS		CITY	STATE	ZIP CODE
DATE EMPLOYED	MEMBER STATUS <input type="checkbox"/> ACTIVELY WORKING <input type="checkbox"/> SURVIVOR OR ANNUITANT <input type="checkbox"/> OTHER		SOCIAL SECURITY NUMBER	

**INSURANCE DESIRED - Check only the plans you are changing.**

**Optional Life (member-paid)**

- 1x Salary       3x Salary
- 2x Salary       4x Salary

**Dependent Life (member-paid)**

- Spouse life coverage equal to \$5000
- Child life coverage equal to \$5000

**APPLICANT INFORMATION - Complete only if changing coverage.**

**Employee**

HEIGHT	WEIGHT	OCCUPATION	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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**Spouse**

FIRST NAME	MIDDLE INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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**HEALTH QUESTIONS - Complete only if changing coverage.**

EMPLOYEE		SPOUSE		CHILD(REN)		
YES	NO	YES	NO	YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever 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 addiction?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 on the reverse side of this form.

The answers provided on this application are representations of each 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 otherwise 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 unless revoked by me in writing. 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 can have copies.

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

EMPLOYEE SIGNATURE <b>X</b>	DAYTIME TELEPHONE NUMBER (      )	EVENING TELEPHONE NUMBER (      )	DATE SIGNED
SPOUSE SIGNATURE <b>X</b>	DAYTIME TELEPHONE NUMBER (      )	EVENING TELEPHONE NUMBER (      )	DATE SIGNED

## CONSUMER PRIVACY NOTICE

In addition to the information requested on this application, the Company may ask for the following: an insurance medical exam or laboratory tests; medical records from your physician, hospital, or your insurance company; an investigative consumer report; a report from the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The Company or its reinsurer may make a brief report of this information to the Medical Information Bureau. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

The Company may also send information about you to the following persons or organizations without your permission: to insurance organizations, for statistical studies, without identifying you; to a government agency involved in regulation of insurance; the Company may also send the results of your insurance exam to your physician.

You have certain rights in connection with this insurance application. You have the right to: find out what personal information is contained in the Company or Medical

Information Bureau files. (Medical information may be disclosed only to your attending physician.); correct or amend information in the Company or Medical Information Bureau files; know the specific reasons why coverage is not issued.

At your request, the Company will explain in writing how you can exercise your right to learn what is in your file, how to correct or amend it, or how to find out why coverage is not issued.

**For further information about your file or your rights, you may contact:**

Group Division Underwriting  
Minnesota Life Insurance Company  
400 Robert Street North  
St. Paul, Minnesota 55101-2098  
(800) 872-2214

**For information about the Medical Information Bureau, you may contact:**

Medical Information Bureau Information Office  
P.O. Box 105, Essex Station  
Boston, Massachusetts 02112  
(MIB telephone number: (617) 426-3660)

**ADDITIONAL HEALTH INFORMATION: SPECIFY BY NAME IF INFORMATION IS FOR APPLICANT, SPOUSE OR CHILD.**

NAME	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT
Employee				
Spouse				
Child(ren)				

**COMPLETE FOR DEPENDENT CHILD(REN) COVERAGE - List Oldest to Youngest**

CHILD'S NAME	CHILD'S BIRTHDATE	SOCIAL SECURITY NUMBER	CHILD'S NAME	CHILD'S BIRTHDATE	SOCIAL SECURITY NUMBER

**FOR GIR USE ONLY:**

<b>Employee</b>		
OPTIONAL IN FORCE <input type="checkbox"/> 0X <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X	ANNUAL BASE SALARY \$	AGENCY NAME
GIR NAME		ORGANIZATIONAL PROCESSING CODE

**FOR HOME OFFICE USE ONLY:**

Employee	Spouse	Child
<input type="checkbox"/> APPR'D <input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.	<input type="checkbox"/> APPR'D <input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.	<input type="checkbox"/> APPR'D <input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.
BY _____ DATE _____	BY _____ DATE _____	BY _____ DATE _____