

Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new coverage or any increases in coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor MICHIGAN STATE POLICE		Group/Plan Number 29615-5	Account Number/Location 001 – ALL ACTIVE EMPLOYEES 002 – ALL RETIRED EMPLOYEES
Class/Occupation	Date of Hire	Annual Salary	Employment Status: <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Retired <input type="checkbox"/> Active Part-Time
This change is due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Other: _____ <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Late Entrant*			Effective Date of Coverage or Change:

**A late entrant is an individual who is first enrolling for coverage after the first available opportunity.*

Employee Information

Employee Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address (street address, city, state, zip code)			Telephone Work () Home ()	

Employee Coverage

Supplemental Life	Guaranteed Issue (GI) Limit = \$130,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. At all other times, an Evidence of Insurability form must be completed and ReliaStar Life must approve it.
Supplemental Employee Life Election	Choice of: <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$130,000
Supplemental Employee and Dependent Life Election	Choice of: <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$130,000 In addition to the employee coverage amount elected above, the following coverage's will apply for your dependents: Spouse: \$10,000 Child(ren) aged 6 months but less than 23 years: \$6,000 Child(ren) over 14 days but less than 6 months of age: \$500
<i>Note: The employee is the beneficiary for any dependent insurance coverage.</i>	
Supplemental Retiree Life Election	Flat Amount: <input type="checkbox"/> \$20,000 Please Note: <i>Retiree Life is available only if you had one of the above employee life options in force at the time you retired.</i>
Supplemental Retiree and Dependent Life Election	Flat Amount: <input type="checkbox"/> \$20,000 In addition to the retiree coverage amount elected above, the following coverage's will apply for your dependents: Spouse: \$3,000 Child(ren) aged 6 months but less than 23 years: \$2,000 Child(ren) over 14 days but less than 6 months of age: \$200
<i>Note: The employee is the beneficiary for any dependent insurance coverage.</i>	

PLEASE TURN OVER TO SIGN AND DATE FORM

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary <i>(last name, first, middle initial)</i>	Relationship to Employee	Benefit % <i>(MUST total 100%)</i>

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed / /
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FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	SUPPL LIFE	SPOUSE LIFE	CHILD LIFE
ACCOUNT			
CLASS			
AMOUNT			
EFF. DATE			