

Group Life Insurance Enrollment



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

UW Employees, Inc. Life Insurance Plan Policy Number: 33977

1. Check one of the following: University of Wisconsin Hospital & Clinics
 University of Wisconsin System
2. Check one of the following: **Enrollment:** I elect to enroll in this plan.
 Cancellation: I elect to cancel coverage in this insurance plan.
 Coverage will terminate on the first of the month after receipt of this form by my employer. I understand if I voluntarily cancel this coverage, I may only reapply with Evidence of Insurability.

3. Return completed form to the Benefits Office.

A. Employee Information			
First name	Middle initial	Last Name	
Email address			
Street address	City	State	Zip code
Date of birth	Last four digits of Social Security Number	Date of Employment	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
B. Authorization			
I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.			
Employee signature X	Daytime telephone number	Evening telephone number	Date signed

For Office Use Only			
Date Received	Received by	Hire Date	Coverage Effective Date
Premium	Processors Initials	Date Processed	Employee ID