

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

EMPLOYER NAME: The Ohio State University
POLICY NUMBER: 33909
OSU

1. If you are electing employee coverage, complete sections 1, 2 and 5.
2. If you are electing coverage on your dependents, complete sections 1, 2 and 5; complete sections 3 and/or 4 as applicable.
3. Visit hr.osu.edu/benefits for additional program information, including eligibility and information on determining need for Evidence of Insurability (EOI).
4. To designate a beneficiary, complete a life insurance designation form.

Note: Beneficiary is the same as GTLI designation; the employee is the beneficiary of any dependent coverage.

SECTION 1: EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Ohio State Employee ID# (required)
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	

Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form? Yes No

SECTION 2: REASON FOR COMPLETING FORM

Date of event: ____/____/____ (return form within 30 days of event date)

Qualifying status change (please specify)¹:

- Hired Newly Eligible Marriage Birth/Adoption/Legal Guardianship²
 Divorce/Dissolution² Late Enrollee (completion of EOI is required) Death of Dependent Child² Death of Spouse²

Employee Life insurance amount requested (not to exceed \$1,000,000)¹:

- 1x Salary 2x Salary 3x Salary 4x Salary 5x Salary 6x Salary 7x Salary 8x Salary Waive

¹Completion of EOI is required for amount above guaranteed issue. Refer to the Life Insurance Specific Plan Details at hr.osu.edu/benefits/life-insurance for more information.

²Documentation may be required

SECTION 3: SPOUSE

First Name	M.I.	Last Name	Daytime Phone Number
Email Address		Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Has your spouse used tobacco in any form during the past 12 months or is your spouse currently using nicotine in any form? Yes No

Life insurance amount requested: \$ _____ Waive

(\$25,000 increments, from \$25,000 to \$300,000.¹)

¹Completion of EOI is required for amount above guaranteed issue. Refer to the Life Insurance Specific Plan Details at hr.osu.edu/benefits/life-insurance for more information.

SECTION 4: CHILDREN INFORMATION (CHILDREN ARE ELIGIBLE FROM LIVE BIRTH TO AGE 26)

Life insurance amount requested: \$5,000 \$10,000 \$15,000 \$20,000

SECTION 5: AUTHORIZATION

I have read and understand the materials describing the terms and conditions of the Voluntary Group Term Life Insurance program, including the Group Term Life Insurance policy, and agree to be bound by such terms and conditions. I certify that the information I have provided in this Enrollment Form is complete and correct. I authorize the university to deduct from my pay, on an after-tax basis, the premiums described in the benefit plan rates online at hr.osu.edu/benefits/rates that are necessary to pay for the life insurance coverage that I have elected above. I understand that this authorization to deduct premiums directly from my pay will remain in effect until I cancel my enrollment or transfer to an ineligible appointment. I understand and agree that in the event my university pay is not sufficient to pay the premiums for this benefit, or if I go on an unpaid leave of absence, I will be billed directly for these premiums. I agree to pay those premiums promptly and in full. I understand that, if premiums are not paid in full, the benefit will be terminated for lack of payment and I will be responsible for premiums missed prior to my coverage termination date. I understand that coverage requiring evidence of insurability (EOI) must be approved by Minnesota Life Insurance Company, a Securian Company. If EOI is approved by Minnesota Life Insurance Company, a Securian Company, any additional coverage elected will be effective as of the approval date designated by Minnesota Life Insurance Company, a Securian Company and is subject to active work and non-confinement requirements. I understand and agree that implementation of my elections may be contingent on the university's approval of consistency with plan terms and IRS rules and, if requested, submission of supporting documentation. 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 _____ Date _____

If you have questions, contact the Office of Human Resources HR Connection:
EMAIL: hrconnection@osu.edu | **WEB:** hrconnection.osu.edu | **PHONE:** 614-247-myHR (6947) or 800-678-6010
Retain a copy of this form for your records. Submission options for the signed original of this form:
UPLOAD to the secure hrconnection.osu.edu portal by selecting "Submit a Form" (recommended)
MAIL to Office of Human Resources, 1590 N. High St., Suite 300, Columbus, OH 43201-2190
FAX to (614)292-7813 | **EMAIL** to hrconnection@osu.edu with subject line "VGTLI"