# State and School Employees' Life Insurance Plan

Underwriter: Minnesota Life Insurance Company

Enrollment in the Mississippi State and School Employees' Life Insurance Plan (Group Life) provides life insurance coverage to the employee at 2x salary raised to the next highest thousand dollar. The minimum coverage available is $30,000 and the maximum is $100,000. An employee who elects to enroll in this plan after 31 days of hire is defined as a 'late applicant' and is required to go through underwriting with Minnesota Life Insurance Company. The effective date of coverage will be determined upon approval by Minnesota Life Insurance Company. Additional information is available on the Human Resources website at http://hr.olemiss.edu/benefits/ by visiting the 'Know Your Benefits' website at http://knowyourbenefits.dfa.ms.gov/minnesota-life-insurance-securian/.

*Employees electing to enroll as a 'late applicant' or cancel existing coverage are required to complete an application. Instructions are provided to guide you through the form completion process. The coverage effective date is based upon the underwriting approval date.*

**All coverage changes become effective January 1, 2018. Completed forms must be received in the University's Human Resources Office (108 Howry Hall) no later than November 3, 2017.**

Coverage enforce on 12/31/2017 will continue at the same level for plan year 2018 in the absence of an open enrollment election/change.

IMPORTANT: PLEASE READ AS ACTION MAY BE REQUIRED.

In order to be in compliance with Form 1095-C and Affordable Care Act requirements, please verify that all names, social security numbers and dates of birth are correct for any family members who are currently enrolled or will be enrolled on an insurance plan. This information can be accessed under the 'Employee' tab and then by clicking the MyHRtools drop down box and selecting Open Enrollment Step 1: Update Beneficiaries / Dependents. If any information is incorrect, please update.

- When enrolling eligible dependents on an insurance plan, a copy of the dependent's Social Security Card **MUST** be provided to the Human Resources office. Furthermore, all listed names on insurance applications must be listed as a legal name, nicknames are not permitted.

- In order to ensure the accuracy of W-2 processing for 2017, please verify all contact information (address, phone number etc.) within myOleMiss. This can be accessed under the 'Employee' tab and then by clicking the MyHRtools drop down box and selecting Address & Communication Preferences. If any information is incorrect, please update accordingly. Please note that updating your contact information within myOleMiss will only update your address with the University, and does not update your contact information with insurance vendors. Please also complete a **Benefits Information Change** form to update your information with each respective vendor and submit the form to 108 Howry Hall. When changing your contact information within myOleMiss, a link to this form will populate on the right side of the screen. You may also access the form via the following link.
  http://hr.wp2.olemiss.edu/wp-content/uploads/sites/93/2016/05/InfoChangeForm.pdf

# Enrollment Application Instructions:

## Enrollment

Employees interested in enrolling in life insurance coverage must complete the following forms.

**State of Mississippi State and School Employees' Life Insurance Plan Enrollment/Change Request Form**

- ***Section A: Employee/Employer Information*** – all fields must be completed
- ***Section B: Coverage*** – mark the box for late enrollee applicant
- ***Page 2*** – provide name, social security number, and daytime telephone number
- ***Section D: Authorization and Certification*** – read certification information then sign and date

***Beneficiary Information*** – Beneficiary designations are made online via the myBlue website. Instructions are provided in Section C.

**Group Life Insurance Evidence of Eligibility**

- ***Employee Information*** – all fields must be completed
- ***Health Questions*** – answer questions 1, 2, and 3 and provide height and weight
- ***Authorization*** – read then sign, date, and provide daytime and evening telephone numbers
- Complete page 2 if applicable

## Cancellation of Existing Coverage

Employees cancelling existing coverage must complete the following sections of the **State of Mississippi State and School Employees' Life Insurance Plan Enrollment/Change Request Form**.

- ***Section A: Employee/Employer Information*** – all fields must be completed
- ***Page 2*** – provide name, social security number, and daytime telephone number
- ***Section E: Waive/Request To Cancel Coverage*** – mark the box for cancellation of coverage then sign and date

## Change in Beneficiary Designation

Beneficiary designations are made online via the myBlue website. Instructions are available at http://knowyourbenefits.dfa.ms.gov/minnesota-life-insurance-securian/.

# STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
# ENROLLMENT/CHANGE REQUEST FORM

**Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.**

## Policy 33683-G

**SECTION A: Employee/Employer Information**

| Employee/Retiree Last Name: | First Name: | MI: | Social Security Number: | Birthdate: (MM/DD/YYYY): |
|---|---|---|---|---|
| Employee/Retiree Home Address: | | | Email Address: | Home Phone:<br>Alternate Phone: |
| Employer Name:<br>The University of Mississippi | | | | Employer Phone:<br>(662) 915-1518 |
| Employer Address:<br>P.O. Box 1848, Department of Human Resources, University, MS 38677 | | | | |

**SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)**

**ACTIVE FULL-TIME EMPLOYEE**: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of $30,000 and a maximum of $100,000. The employee and employer each pay 50 percent of the monthly premium.

**New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

☐ **Late Enrollee Applicant** – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. (**Employee must also complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form*.**)

**Date of Employment:** _____

**RETIRED EMPLOYEE:** Life benefit amounts are limited to $5,000, $10,000 or $20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

**Date of Retirement:** _____ **COVERAGE AMOUNT REQUESTED:** **$5,000** **$10,000** **$20,000**

**DISABLED EMPLOYEE:** Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.

**(Employee must also complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)**

**Date of Disability:** _____

**SECTION C: Beneficiary Information**

**NOTE: You cannot designate your life insurance beneficiary on this form**. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your *my*Blue site, **https://myblue.bcbsms.com**, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the *my*Blue portal.

**If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.**

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

| Employee/Retiree Last Name | First Name | MI | Social Security Number | Daytime Phone |
|---|---|---|---|---|
| | | | | |

**SECTION D: Authorization and Certification**

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____

**Employee/Retiree Signature (Required)** **Date**

**SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)**

**Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

☐ **Cancellation of Coverage** – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

**SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.**

_____ _____

**Employee/Retiree Signature** **Date**

**FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT http://KnowYourBenefits.dfa.ms.gov/ OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.**

| FOR PERSONNEL/PAYROLL USE ONLY | | | |
|---|---|---|---|
| COVERAGE AMOUNT: | REQUESTED EFFECTIVE DATE: | GROUP NUMBER: | INFORMATION VERIFIED: (INITIAL AND DATE) |
| | | | |

# Group Life Insurance Evidence of Insurability

**Minnesota Life Insurance Company** - A Securian Company
400 Robert Street North ● B1-3102 ● St. Paul, Minnesota 55101-2098 ● Fax 651-665-7092

MINNESOTA LIFE

**EMPLOYER NAME: Mississippi State and School Employees' Life Insurance Plan** **POLICY NUMBER: 33683**

| Employer unit name | Employer unit number |
|---|---|
| **University of Mississippi** | |

## EMPLOYEE INFORMATION

| First name | Middle initial | Last name | Email address |
|---|---|---|---|
| | | | |

| Street address | City | State | Zip code |
|---|---|---|---|
| | | | |

| Date of birth | Social Security number | Date of employment | Gender |
|---|---|---|---|
| | | | ☐ Male ☐ Female |

## HEALTH QUESTIONS

| Employee Yes | Employee No | Employee Height | Employee Weight | |
|---|---|---|---|---|
| ☐ | ☐ | | | 1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized? |
| ☐ | ☐ | | | 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? |
| ☐ | ☐ | | | 3. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (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 you answer yes to any question, give details including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment in the Additional Health Information Section on the second page or on a separate sheet of paper.

## AUTHORIZATION

The answers provided on this application are representations of the 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. If I do not revoke this authorization, it will be valid for 24 months from the date I sign it. A photocopy shall be as valid as the original. I have read this Authorization and the Consumer Privacy Notice on the second page and I understand that I can have copies.

| Employee signature | Daytime telephone number | Evening telephone number | Date signed |
|---|---|---|---|
| **X** | | | |

## CONSUMER PRIVACY NOTICE

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

**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
Telephone: (800) 872-2214

**For information about the MIB, you may contact:**

MIB
50 Braintree Hill, Suite 400
Braintree, MA 02184-8734
MIB Telephone: (866) 692-6901
MIB TTY: (866) 346-3642
Website: www.mib.com

## ADDITIONAL HEALTH INFORMATION

| NAME | DATE | NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL | REASON FOR CONSULTATION | DIAGNOSIS AND TREATMENT |
|---|---|---|---|---|
| | | | | |

## For Employer Unit Office Use Only - Validation of Eligibility Required

**POLICY NUMBER: 33683**

| Employer unit number | Employer unit |
|---|---|
| | |

Underwritten amount equals 2x basic annual earnings (2x rounded to the next higher $1,000; minimum of $30,000 up to a maximum of $100,000)
$

| Is employee eligible for the coverage? ☐ Yes ☐ No | Employer unit signature<br>**X** |
|---|---|

## For Minnesota Life Use Only

Required application entry
Total Multiple = 2
Underwritten Multiple = 2
Underwritten Amount = see above