securian FINANCIAL | Ochs

Group Name

Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

Insurance products issued by Minnesota Life Insurance Company or Securian Life Insurance Company and administered by Ochs.

Life Insurance Coverage Available - No Health Questions!

There are many reasons to consider Supplemental Life Insurance and there are certain times in which you can enroll for coverage without answering health questions. **Below is a summary of those options.**

Looking for a higher amount of coverage? A full list of your life insurance coverage options is outlined on the following pages. To apply for coverage other than the amounts listed below, health questions and underwriting approval is required.

NEW HIRE OPPORTUNITY

New hire eligibility refers to when you are hired and become eligible for benefits.

- ✓ **Employee** - up to **$200,000**
- ✓ **Spouse** - up to **$20,000**
- ✓ **Child - all coverage**

ANNUAL ENROLLMENT OPPORTUNITY

Available during your employer's annual enrollment period.

- ✓ **Child - all coverage**

QUALIFIED STATUS CHANGE

If you experience An employment or family status change, check with your employer within 31 days to confirm guaranteed coverage availability.

Your Basic and Supplemental Life Insurance Coverages:

Basic Life Coverage - 100% employer paid & automatically enrolled		
Basic term life	**$15,000**	✓ Includes a matching AD&D benefit ✓ Coverage reduces beginning at age 65
Supplemental Life Coverage - 100% employee paid		
Supplemental term life	Elect in **$10,000** increments Maximum **$500,000**	✓ Coverage reduces beginning at age 65
Spouse term life	Elect in **$10,000** increments Maximum **$150,000**	✓ Cannot exceed 100% of employee's basic & supplemental coverage combined
Child term life	Elect **$10,000** or **$15,000**	✓ Includes 1st newborn child benefit ✓ Cannot exceed 100% of employee's basic & supplemental coverage combined ✓ Available to elect without health questions each annual enrollment

If your spouse or child is eligible for employee coverage, they cannot also be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible.

Monthly Cost:

Employee or Spouse Supplemental Life	
Age	**Rate per $1,000**
<25	$0.00
25-29	$0.00
30-34	$0.00
35-39	$0.00
40-44	$0.00
45-49	$0.00
50-54	$0.00
55-59	$0.00
60-64	$0.00
65-69	$0.00
70-74	$0.00
75*	$0.00

*Rates beyond age 75 are available upon request.
Rates increase with age and all rates are subject to change.

Here's how to calculate your monthly premium:

Total supplemental term life coverage amount	$_____
÷ 1,000	$_____
× your rate (based on your age)	$_____
= Monthly premium	**$_____**

Here's how Riley calculated their monthly premium:

Riley elected a total supplemental term life coverage amount of	$150,000
÷ 1,000	$150.00
× Riley's rate (based on their age of 42)	$0.00
= Riley's monthly premium	**$00.00**

Child Life	
$10,000	**$15,000**
$0.00	$0.00

One premium covers all eligible children from live birth to age 26

Why Life Insurance?

No matter where you are in life, there are many reasons to consider Life Insurance. Group Life Insurance protects you and your family from the unexpected loss of life and income during working years. AD&D Insurance provides additional financial protection if the insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere. Life and AD&D Insurance benefits are disbursed to you and/or your beneficiaries to help pay for things like:

- ✓ Your mortgage or rent
- ✓ Childcare or education costs
- ✓ Medical bills or other expenses
- ✓ Funeral and burial costs

How much Life Insurance do I need?

To estimate the amount of Life Insurance you need, you'll want to determine what you must protect in the event of your death. Determine your needs today.

Check out our Life Insurance calculator: click here.

Or scan here:

Naming a Beneficiary:

Naming a beneficiary is an important right of Life Insurance ownership; this determines who receives the death benefit. It is recommended that you review and update your beneficiaries periodically. Events such as marriage, birth/adoption of children, divorce or death may change how you want your Life Insurance benefit paid.

Continuation:

If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage after employment. No health questions are needed and rates are generally higher than active rates. If you would like to

Questions **ochs@ochsinc.com** **800-392-7295**

Ochs, Inc.
A Securian Financial Company
400 Robert Street N, Ste. 1880, St. Paul, MN 55101

Group Term Life Insurance Enrollment

Securian Life Insurance Company
Administered by Ochs, Inc. • 18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025
1-800-392-7295 • Fax 651-665-3791

EMPLOYER NAME: **POLICY NUMBER:**

EMPLOYEE INFORMATION

Name (first, middle initial, last)	Date of birth	
Address (street, city, state, zip)	Email address	
Date of employment	Annual salary	Sex ☐ Male ☐ Female

If request is due to a family status change, indicate date of change

Basic Life Insurance

Basic Life Amount $_____ Insurance Class _____ Effective Date _____

Supplemental Life Insurance

Employee
Current Amount $_____ ☐ Increase ☐ Decrease Amount $_____ Grand Total $_____ Effective Date _____

Spouse
Current Amount $_____ ☐ Increase ☐ Decrease Amount $_____ Grand Total $_____ Effective Date _____

Child
Current Amount $_____ ☐ Increase ☐ Decrease Amount $_____ Grand Total $_____ Effective Date _____

SPOUSE INFORMATION (only complete if electing coverage)

Name (first, middle initial, last)	Date of birth	Social Security number
Address (street, city, state, zip; check here if same as above ☐)		Sex ☐ Male ☐ Female
Email address		

CHILDREN INFORMATION (only complete if electing coverage)

Name (first, middle initial, last)	Date of birth

AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for this insurance coverage. I've read the fraud warnings on the reverse side.

Employee signature	Phone number	Date signed
X		

Group Life Insurance Evidence of Insurability

Securian Life Insurance Company
Administered by Ochs, Inc.
18-3789 • 400 Robert Street North, St. Paul, MN 55101-2025
1-800-392-7295 • Fax 651-665-3791

EMPLOYER NAME: **POLICY NUMBER:**

LOCATION: **CLASS/EMPLOYER CODE:**

EMPLOYEE INFORMATION

Name (first, middle initial, last)	Date of birth	Phone number

Address (street, city, state, zip)

Gender ☐ Male ☐ Female	Annual salary	Date of employment	Social Security number

Total amount of insurance requested $	Email address

SPOUSE INFORMATION (only complete if coverage requires evidence of insurability)

Name (first, middle initial, last)	Date of birth	Phone number

Address (street, city, state, zip; check here if same as above ☐)

Gender ☐ Male ☐ Female	Email address

Total amount of insurance requested
$

HEALTH QUESTIONS (always complete for coverage that requires evidence of insurability)

Employee height	Employee weight	Spouse height	Spouse weight	Spouse occupation

Employee Yes	Employee No	Spouse Yes	Spouse No	
☐	☐	☐	☐	1. In the last 7 years have you been diagnosed or treated for any of the following: • Heart disease or disorder, chest pain • High blood pressure • Cancer or tumor • COPD, sleep apnea or other lung or respiratory disease • Stroke, TIA, seizure, epilepsy, or multiple sclerosis • Kidney or pancreas disorder • Ulcerative Colitis, Crohn's disease, bariatric surgery, or any stomach or intestinal disorder • Anemia, leukemia, or other blood disorder • Hepatitis B, Hepatitis C, or other liver disorder • Diabetes • Depression, bipolar disorder, or any mental disorder • Drug or alcohol misuse including addiction • Chronic pain, rheumatoid arthritis, psoriatic arthritis, lupus • AIDS, AIDS Related Complex, or HIV, including positive test results • ALS or muscular dystrophy
☐	☐	☐	☐	2. During the past 5 years, have you, for any reason other than the conditions in question 1, been hospitalized, had surgery, received medication, treatment or diagnostic testing (other than: acid reflux; allergies; birth control; high cholesterol; cold; appendix or gallbladder removal; underactive thyroid; kidney stones; pregnancy without complications; or minor infection)?

Securian Financial is the marketing name for Securian Life Insurance Company. Insurance products are issued by Securian Life Insurance Company, a New York authorized insurer.

⇨⇨⇨⇨⇨ **Please provide details to all "Yes" answers on page 2 and sign page 3** ⇨⇨⇨⇨⇨

EMPLOYER NAME: **POLICY NUMBER:**

LOCATION: **CLASS/EMPLOYER CODE:**

Employee Yes	Employee No	Spouse Yes	Spouse No	
☐	☐	☐	☐	3. Are any future inpatient or outpatient medical, surgical, or diagnostic procedures recommended or being considered by a medical professional (other than: routine lab testing or physical)?

ADDITIONAL HEALTH INFORMATION (provide details for every "Yes" answer to the health questions)

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

CONSUMER PRIVACY NOTICE

To underwrite your insurance request, Securian Life Insurance Company, (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 MIB, Inc., a not-for-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. If you apply to a MIB, Inc. member company for life or health insurance, or submit a benefits claim for benefits to a member company, MIB, Inc. 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, Inc. 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 the Company 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:

Life Underwriting
Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: 800-872-2214

For information about MIB, Inc. you may contact:

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

➪➪➪➪➪➪➪➪➪➪➪➪➪➪➪➪ **Please sign page 3** ➪➪➪➪➪➪➪➪➪➪➪➪➪➪➪➪

EMPLOYER NAME: **POLICY NUMBER:**

LOCATION: **CLASS/EMPLOYER CODE:**

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, data aggregator, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Securian Life Insurance Company, (the Company), and its employees, reinsurers and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

I also authorize any person(s), medical practitioner, institution, insurance company or MIB, Inc. 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, Inc., to give such information to any agency employed by the Company to collect and transmit such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

This protected health information is to be disclosed under this Authorization so the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand I am entitled to receive a copy of this Authorization. I understand the information may be used for the purpose of performing actuarial or internal business studies, research, analytics and other analysis. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation does not apply to any action that was taken in reliance on this Authorization or to the Company's legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I have read this Authorization and Consumer Privacy Notice and I understand I can have copies. The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Securian Life Insurance Company 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 authorize my employer to withdraw premiums from my salary to pay for this coverage. 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. Any person who, with intent to defraud or knowing that he/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 **X**	Date signed	Employee name (please print)	Date of birth
Spouse signature **X**	Date signed	Spouse name (please print)	Date of birth

FOR OFFICE USE ONLY:

Employee		**Spouse**	
Current in force **$**	U/W applied for **$**	Current in force **$**	U/W applied for **$**

Beneficiary Designation

Securian Life Insurance Company
Minnesota Life Insurance Company

Administered by Ochs, Inc.
Group Customer Service • 400 Robert Street North, Suite 1880, St. Paul, MN 55101-2025

INSTRUCTIONS

1. Clearly print or type the information.
2. Sign and date the completed form.
3. Return to:

GENERAL BENEFICIARY INFORMATION

- Completing this Beneficiary Designation form will revoke all current beneficiary designations.
- The same person(s) cannot be named as both a primary and contingent beneficiary.
- If you need more space, attach an additional sheet of paper with all of the information required. Be sure to sign and date this additional information page.
- To receive a death benefit, a beneficiary must survive the insured. If the named beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category.
- When the signed and completed beneficiary form has been accepted, you will be mailed a confirmation.
- **Primary Beneficiary:** This is the individual(s), trust, charity, or estate that you want to receive the insurance benefit. You can divide the insurance proceeds between primary beneficiaries. The total shares must equal 100%.
- **Contingent Beneficiary:** If all the primary beneficiary(ies) are no longer living, eligible, or able to receive the benefits, it will be paid to the contingent beneficiary(ies) designated. You can divide the insurance proceeds between your named contingent beneficiaries. The total shares must equal 100%.
- **Naming Minor Children:** You may name your children (by name) directly, or to a trust. Minors cannot directly receive life insurance proceeds; however, they may be paid to a court-appointed guardian or held until the minor child is legal age.
- **Trust:** Provide the trust name, effective date and tax ID or Social Security number (if applicable) - i.e., "John Smith Trust dated 01/01/20xx."
- **Charity:** Provide the full name, address, tax ID number.

CONTINUE ON TO NEXT PAGE

Beneficiary Designation

Securian Life Insurance Company • Minnesota Life Insurance Company

Employer name			Policy number
Insured's name (first, middle initial, last)			ID (or last four of SSN)
Address (street, city, state, zip)		Email address	
Insured's date of birth	Policyowner (if different than insured)		Policyowner's phone number

This designation applies to selected coverage(s). If this section is left blank, your designation will apply to all coverages. If your beneficiary(ies) are different by coverage, use a separate beneficiary form for each coverage.

☐ All coverages ☐

☐ ☐

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

Total Primary Shares Must Equal 100%

CONTINGENT BENEFICIARY(IES) - Receives a benefit ONLY if all primary beneficiaries are no longer living.

Beneficiary full name/trust name	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary full name	Date of birth	Tax ID (SSN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

Total Contingent Shares Must Equal 100%

SIGNATURE REQUIRED - This beneficiary form revokes all prior designations.

Insured or policyowner's penned signature	Date
X	

Community Property State Consent for current and former residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married and live in, or previously lived in, a community property state and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit. You should consult with a qualified tax advisor and/or seek legal advice if you have any questions in connection with the Beneficiary Designation.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any right that I may have to the proceeds of such insurance under applicable community property laws. My spouse may withdraw this designation at any time but may not designate a different primary beneficiary without my consent.

Signature of spouse	Please print spouse name clearly	Date signed
X		