UPlan

Application for Optional Life Insurance

Office of Human Resources
University of Minnesota

Request to Increase Coverage with Evidence of Insurability or Request to Decrease Coverage

After your first 30 days of employment or eligibility, or more than 30 days following the date of a life event such as marriage or birth/adoption of a child, you must complete an application for optional life insurance with evidence of insurability. Refer to the *Guide for UPlan Benefits Enrollment* or the Employee Benefits website at humanresources.umn.edu/benefits for specific information about rates and applying for coverage. For example, you can add coverage for your spouse or child within 30 days due to a life event, but you must submit evidence of insurability to increase additional employee life.

The pending coverage will be sent to Securian for underwriting. They will send you a password so that you can complete the evidence of insurability directly on their online system. Changes to optional life insurance will be effective the first day of the pay period coinciding with or next following notice of Securian's approval of an increase in coverage or the receipt of this application for a decrease in coverage.

Employee Information (Please print)

Last Name | First Name | MI | Date of Employment

Street Address | City | State | Zip Code

Employee ID Number | Work Phone Number | E-mail Address

Optional Life Insurance Enrollment

Type of Optional Coverage Requested	Optional coverage you have now	Coverage increase requested (+)	Coverage decrease requested (-)	New total of optional coverage (=)
❑ **Additional Employee Life (Do not include amount of Basic Life)**	$	$	$	$
❑ **Spouse Life**	$	$	$	$
❑ **Child Life ($10,000)**	$	$	$	$

Dependent Enrollee Information (Please print)

Spouse:

Last Name | First Name | MI | Social Security Number | Date of Birth | Gender

Child/Children:

Last Name | First Name | MI | Social Security Number | Date of Birth | Gender

Last Name | First Name | MI | Social Security Number | Date of Birth | Gender

Last Name | First Name | MI | Social Security Number | Date of Birth | Gender

Address for Dependents if different than Employee Address:

Street | City | State | Zip Code

Employee Authorization (Please read before signing)

I am applying for or changing coverage in the Optional Life Insurance Plans offered by the University of Minnesota, as indicated above, subject to approval of my eligibility. I authorize the University of Minnesota to disclose the foregoing information to Securian who has contracted to provide this benefit to participants of the program for use in determining my eligibility and processing my application for coverage. I also authorize the University of Minnesota to deduct the premiums for this coverage through payroll, and I understand that my deduction amount will change if my coverage or costs change. I understand that false or incorrect answers to evidence of insurability questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee Signature **Date**

Employee Benefits Use Only

Remarks _____

U of M: _____ Date: _____

Please make a copy for your records and return completed form to Employee Benefits by campus mail at 200 Donhowe Bldg, Del Code 3122 or by U.S. mail at 200 Donhowe Bldg , 319 15th Avenue SE, Minneapolis MN 55455-0103

Information and Privacy — There are laws to protect your rights.

Several state and federal laws aid in protecting your rights to privacy and make it easier for you to review information in your insurance file. Under one of these laws – the Minnesota Government Data Practices Act (Minnesota Statutes 13.01-13.43) – you have the right to know the following.

A. Why the information is needed

The information we request about you, your employment, and family members is needed for one or more of the following reasons:

- To determine whether you are eligible for University of Minnesota UPlan coverage
- To establish the amount of insurance coverage for which you are eligible
- To determine the amount of deductions from your paycheck to pay your rate contributions

B. Supplying information – your rights

- **Minnesota Statute 13.04**. You may refuse to provide the information we request; however, without certain minimal information, we may be unable to process your application for coverage under the group plan.
- **Federal Privacy Act of 1974; Public Law 93-579.** Disclosure of your Social Security number is voluntary. The information is requested to identify your records in the Employee Benefits system and the records of the claims administrators. While you are not legally required to furnish this information, processing of your application for group benefits will be delayed without it.

C. Who uses the information and how it is used

The information we collect will be used by University employees operating the group benefits program, the payroll system, federal and state tax authorities, and shared with the claims administrators involved in your benefits coverage.

Depending on the coverage you request (and are eligible for), the information may be used to:

- Provide enrollment and/or change information to your claims administrators so they can provide benefits and pay claims
- Conduct quality improvement initiatives
- Prepare statistical reports and evaluative studies

When you are no longer an active participant under the group benefits program, we will keep your file until state retention requirements are met.

D. What information you can access

You may request in writing to be shown information about yourself that is maintained by our department. There is no charge for this service, but there is a small copy charge should you need copies.