



Minnesota Life Insurance Company • B1-3102 • 400 Robert Street North • St. Paul, Minnesota 55101-2098 • Fax: 651-665-6480

EMPLOYER NAME: University of Missouri

POLICY NUMBER: 32898

- 1. Always provide employee information and sign the request.
2. Complete the Basic Life, Dependent Life-spouse, Dependent Life-child(ren) and Health Questions sections applicable to your request.
3. Submit the completed form(s) to your Campus Benefit Representative.

EMPLOYEE INFORMATION

Form with fields: FIRST NAME, MIDDLE INITIAL, LAST NAME, BENEFIT ELIGIBILITY DATE, SOCIAL SECURITY NUMBER, STREET ADDRESS, CITY, STATE, ZIP CODE

BASIC LIFE INFORMATION

Basic Life Option Requested: No Change, Life A (1x salary), Life B (2x salary); DATE OF BIRTH, HEIGHT, WEIGHT

DEPENDENT LIFE - SPOUSE INFORMATION

Spouse Life Option Requested: No Change, \$10,000, \$20,000, \$30,000, \$40,000, \$50,000; SPOUSE ELIGIBILITY DATE

Form with fields: FIRST NAME, MIDDLE INITIAL, LAST NAME, DATE OF BIRTH, SOCIAL SECURITY NUMBER, STREET ADDRESS, CITY, STATE, ZIP CODE

E-MAIL ADDRESS, GENDER (MALE, FEMALE), HEIGHT, WEIGHT, OCCUPATION

DEPENDENT LIFE - CHILD(REN) INFORMATION

Child(ren) Life Option Requested: No Change, \$5,000, \$10,000, \$15,000, \$20,000, \$25,000

List names and dates of birth for your eligible children below:

Table with columns: Name, Date of Birth, Eligibility Date (repeated for multiple children)

HEALTH QUESTIONS

Grid for health questions with columns: EMPLOYEE, SPOUSE, CHILD and rows: YES, NO for each category

- 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 particulars 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.

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.

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.

Form with fields: EMPLOYEE SIGNATURE, SPOUSE SIGNATURE, DAYTIME TELEPHONE NUMBER, EVENING TELEPHONE NUMBER, DATE SIGNED

CONSUMER PRIVACY NOTICE

In addition to the information requested on this application, the Company may ask for the following: an insurance medical exam or laboratory tests; medical records from your physician, hospital, or your insurance company; an investigative consumer report; a report from the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The Company or its reinsurer may make a brief report of this information to the MIB. If you apply to another MIB member company for life or health insurance coverage, or claim for benefits is submitted to such company, the MIB, upon request, will supply such company with the information in its file. The Company may also send information about you to the following persons or organizations without your permission: to insurance organizations, for statistical studies, without identifying you; to a government agency involved in regulation of insurance; to your physician (the results of your insurance exam). You have certain rights in connection with this insurance application. You have the right to: find out what personal information is contained in the Company or MIB files; correct or amend information in the Company or MIB files; know the specific reasons why coverage is not issued. At your request, the Company will explain in writing how you can exercise your right to learn what is in your file, how to correct or amend it, or how to find out why coverage is not issued.

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
 800-872-2214

For information about the Medical Information Bureau, you may contact:

Medical Information Bureau Information Office
 P.O. Box 105, Essex Station
 Boston, Massachusetts 02112
 617-426-3660

ADDITIONAL HEALTH INFORMATION

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

FOR CAMPUS USE ONLY:

FOR HOME OFFICE USE ONLY:

Employee

CURRENT IN FORCE	ADDITIONAL AMOUNT	TOTAL AMOUNT
\$	\$	\$

<input type="checkbox"/> APPROVED	BY	DATE
<input type="checkbox"/> DECLINED		
<input type="checkbox"/> INCOMPLETE		

Spouse

CURRENT IN FORCE	ADDITIONAL AMOUNT	TOTAL AMOUNT
\$	\$	\$

<input type="checkbox"/> APPROVED	BY	DATE
<input type="checkbox"/> DECLINED		
<input type="checkbox"/> INCOMPLETE		

Child

CURRENT IN FORCE	ADDITIONAL AMOUNT	TOTAL AMOUNT
\$	\$	\$

<input type="checkbox"/> APPROVED	BY	DATE
<input type="checkbox"/> DECLINED		
<input type="checkbox"/> INCOMPLETE		

LOCATION

EMAIL ADDRESS

CAMPUS REPRESENTATIVE SIGNATURE

DATE

PHONE NUMBER

X