



Return form to: Minnesota Life Insurance Company • B2-4930 • 400 Robert Street North • St. Paul, Minnesota 55101-2098

EMPLOYER NAME: UNIVERSITY OF MISSOURI

POLICY NUMBER: 32898

1. Always provide employee information and sign the request.
2. Update information applicable to your requested change(s).
3. Complete Evidence of Insurability form if you are an active employee requesting a coverage increase.
4. Submit the completed form(s) to your Campus Benefit Representative.

EMPLOYEE INFORMATION (PLEASE PRINT)

FIRST NAME	MIDDLE INITIAL	LAST NAME
EMAIL ADDRESS		SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY
		STATE
		ZIP CODE

Are you actively working at your employer's normal place of business at least 30 hours per week? Yes No

CHANGE BENEFICIARY (FOR SUPPLEMENTAL COVERAGE ONLY - REVOKING ALL PRIOR DESIGNATIONS)

PRIMARY BENEFICIARY NAME(S) AND ADDRESS(ES)	SOCIAL SECURITY NUMBER(S)	SHARE %
CONTINGENT BENEFICIARY NAME(S) AND ADDRESS(ES)	SOCIAL SECURITY NUMBER(S)	SHARE %

CHANGE EMPLOYEE COVERAGE

CURRENT MULTIPLE OF INSURANCE	NEW TOTAL MULTIPLE OF INSURANCE (current and requested)
<input type="checkbox"/> 1X salary <input type="checkbox"/> 2X salary <input type="checkbox"/> 3X salary	<input type="checkbox"/> none/cancel coverage <input type="checkbox"/> 1X salary <input type="checkbox"/> 2X salary <input type="checkbox"/> 3X salary Plan minimum is the greater of \$20,000 or 1 times your annual salary. Coverage is rounded to the next higher \$5,000 if not already an even multiple.
ANNUAL SALARY	PAY FREQUENCY
	<input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Check here if you receive nine paychecks per year

AUTHORIZATION

I authorize the above noted changes and I authorize my employer to withdraw any applicable optional term insurance premiums from my paycheck.

EMPLOYEE SIGNATURE	DAYTIME TELEPHONENUMBER	EVENING TELEPHONE NUMBER	DATE SIGNED
X			

FOR CAMPUS USE ONLY

LOCATION	EMAIL ADDRESS
CAMPUS REPRESENTATIVE SIGNATURE	TELEPHONE NUMBER
X	DATE