

Group Supplemental Life Insurance Enrollment

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

EMPLOYER NAME: Cook County of Illinois

POLICY NUMBER: 34440

1. Complete sections A, B, and C.
2. Return completed and signed form to **Risk Management, Employee Benefits Division:** 118 N. Clark, Room 1072, Chicago, IL 60602-1304 or fax form to 866-729-3040 (toll-free) or email risk.mgmt@cookcountyil.gov.

A. 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Total amount of supplemental insurance requested \$				

B. BENEFICIARY INFORMATION

Primary beneficiary name(s) and address	Relationship	Share % (must total 100%)
Contingent beneficiary name(s) and address (<i>Contingent beneficiaries collect only if all primary beneficiaries predecease the insured.</i>)	Relationship	Share % (must total 100%)

C. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.

Employee signature X	Daytime telephone number	Evening telephone number	Date signed
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