Employee Benefits

ACCIDENT INSURANCE APPLICATION (MN)

ReliaStar Life Insurance Company, Minneapolis, MN
Administrative Office: PO Box 122, Minneapolis, MN 55440-0122

PLAN INFORMATION

Group Policyholder Name Bloomington Independent School District #271

Group Number 65768-9

ENROLLMENT TYPE

☐ Initial Enrollment ☐ Regular Enrollee[1] (New Hire) ☐ Special Enrollment

☐ Re-Enrollment ☐ Late Entrant[2] ☐ Other _____

[1]A regular enrollee is a new employee applying at the first available opportunity.
[2]A late entrant is an employee applying after the first available opportunity, with the exception of special enrollment offers.

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____

Birth Date *(Month, Day, Year)* _____ Social Security # _____ Gender: ☐ Female ☐ Male

E-mail Address _____

Residence Address _____ City _____ State _____ ZIP _____

Residence or Cell Phone (_____) _____ Work Phone (_____) _____

Proposed Effective Date of Coverage OR Date of Change *(Month, Day, Year)* _____ Age on Proposed Effective Date _____

Hire Date *(Month, Day, Year)* _____ Job Title / Occupation _____

Employee ID # _____ Employee Class _____

Is the Employee Actively At Work? ☐ Yes ☐ No The Employee is Scheduled to Work _____ Hours Per Week

Pay Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Department # _____ Location # _____

COVERAGE REQUESTED

☑ Employee Accident Insurance
☐ Spouse Accident Rider
☐ Children's Accident Rider

Is each person to be insured also covered under a Qualified Major Medical Plan? ☐ Yes ☐ No
(Persons who are not covered by a qualified major medical plan are not eligible for this coverage.)

SPOUSE INFORMATION *(Complete only if applying for Spouse Accident Rider.)*

Name *(First, Middle Initial, Last)* _____ Gender: ☐ Female ☐ Male

Birth Date *(Month, Day, Year)* _____ Age on Proposed Effective Date _____

ACKNOWLEDGMENTS AND AUTHORIZATIONS

Insurance benefits are contingent on proof of loss. Benefits may require medical information from your health care provider.

It is understood and agreed that this application shall be made a part of the coverage applied for and that no insurance shall be effective until approved by the company at its home office, regardless of when the first premium is paid.

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my insurance coverage purchased through ReliaStar Life Insurance Company. This authorization and assignment will remain in effect until revoked by me in writing to my Employer. I understand that my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am in active employment.

This application is part of the Policy and subject to the terms and conditions of the Policy. I understand that no agent, representative or employee of ReliaStar Life Insurance Company, my Employer or any other entity may change or waive the requirements of this application, or the terms of the Policy, the Certificate or any riders, except as specifically set forth in the Policy.

Employee Signature _____ Date _____

Signed At *(City & State)* _____