

Additional Life Insurance
POST-RETIREMENT BENEFIT APPLICATION
For Retirements on or after January 1, 2024

State of Minnesota - AGE 65 AND OVER RETIREE Policy Number: 7166

Full name: _____ Phone: _____

Address: _____

Social Security number: _____ Date of birth: _____ Retirement date: _____

I. RETIREE

NOTE: Retirees who have qualified for, elected, continued or received the post-retirement employee supplemental life and/or optional spouse life benefit(s) are not entitled to enroll in the supplemental employee and/or optional spouse coverage as a rehired employee upon return to employment with an agency that is covered by the State Employee Group Insurance Program.

This applies to any retiree who has obtained the 20% paid-up policy OR who is continuing to pay for optional life coverage prior to age 65.

Your post-retirement benefit will be 20% of the amount shown.

☐ I elect the 20% paid-up death benefit.

I understand that:

- Premiums increase based on age.
- The insurance premium will be billed on a semiannual basis.
- If I fail to pay premiums within the 31-day grace period, my coverage will lapse and cannot be reinstated.
- All employee premiums must be paid through the end of the month that includes my retirement date.
- Any increase of this coverage that has not been in force for the required five (5) year period will not be eligible for the 20% post-retirement benefit.

☐ I elect to waive this offer to continue my additional life insurance. By opting waive I am declining the no-cost 20% paid up death benefit.

IMPORTANT NOTICE TO RETIREE: This form certifies your eligibility for this post-retirement benefit and identifies the amount of life insurance that will continue on your life. Please retain this document along with a certificate which you can access online at: mn.gov/mmb/segip. If you have any questions concerning this benefit, you can call Minnesota Life at 1-877-494-1714.

Date	Retiree signature X
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II. HUMAN RESOURCES

Complete and verify above information and certify that the individual is eligible for an immediate retirement annuity and therefore eligible for the employee post-retirement life insurance benefit.

Date	Agency HR representative signature X	Last premium payment was for the pay period or month ending
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III. SEGIP

Complete and verify the following information. The smallest amount of additional employee life insurance coverage in force during the five (5) year period immediately prior to retirement was \$_____.

Date	Employee insurance section signature X
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Send to: Minnesota Management and Budget - SEGIP, 400 Centennial Office Bldg., 658 Cedar St., St. Paul, MN 55155

Retain a copy for department file - Provide a copy to retiree

See page 2 to designate or change your beneficiary →

Retiree name (first, last)	Last four digits of SSN
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DESIGNATE OR CHANGE YOUR BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS*

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive death proceeds. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children," without modification, includes only your biological children of first generation and legally adopted person. For revocable designations, this signed beneficiary, when accepted by Minnesota Life, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive death proceeds, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death proceeds will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

Primary beneficiary(ies) - The person or persons named will receive the proceeds.

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Contingent beneficiary(ies) - If the primary beneficiary(ies) is no longer living, the benefit is paid to the person or persons.

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Policyholder's signature X	Date
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*** must name beneficiaries for this benefit (current beneficiaries will not be assumed)**

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