MBA Insurance Application and/or CHANGE FORM

MBA™ Minnesota Bankers Association — The Champion for Minnesota Bankers

CHECK ALL THAT APPLY

☐ Enrollment	☐ Birth or Adoption	☐ Name Change	☐ Loss of Coverage	☐ Divorce, Separation or Death
☐ Termination (last day worked):	☐ Marriage	☐ Address Change	☐ Other Change	☐ Change of Spouse's Employment
	☐ Waiver	☐ Beneficiary Change	☐ COBRA/Life Cont.	☐ Date of Change:

REQUIRED

Employee Name (first)	MI	Last Name	Prior Name (if changing)

Employee Address (Dental Only)	CITY/STATE	ZIP CODE	Part-time employment date:	Full-time employment date:

Employee Date of Birth:	Gender	Married	Officer	Earnings (for Life/Disability): $_____	Employee Social Security Number
	☐ M ☐ F	☐ Y ☐ N	☐ Y ☐ N	☐ Hourly – No. of hours per week _____	
Job Title or Position				☐ Weekly ☐ Monthly ☐ Yearly	Employment Location/Bank Name
				☐ Other _____	

WAIVER

WAIVER OF BENEFIT: THE GROUP INSURANCE AVAILABLE THROUGH MY EMPLOYER HAS BEEN EXPLAINED TO ME. AFTER CAREFUL CONSIDERATION I HAVE DECIDED THAT I DO NOT WANT TO ENROLL IN ONE OR MORE PLANS. COVERAGE MAY NOT BE WAIVED FOR 100% EMPLOYER PAID PLANS.

I WISH TO WAIVE MY RIGHT TO AND NOT APPLY FOR: LIFE INSURANCE ☐ Basic ☐ Optional ☐ Dependent ☐ LTD ☐ STD ☐ Dental

I UNDERSTAND THAT IF I WANT TO BECOME INSURED LATER FOR LIFE AND DISABILITY I WILL BE REQUIRED TO PROVIDE INSURING CARRIER WITH SATISFACTORY EVIDENCE OF INSURABILITY AND THAT INSURING CARRIER WILL HAVE THE RIGHT TO REFUSE MY REQUEST FOR INSURANCE. PLEASE SIGN THE BOTTOM OF THIS FORM. IF WAIVING DENTAL COVERAGE, A WAITING PERIOD MAY APPLY IF COVERAGE IS REQUESTED AT A LATER DATE.

ENROLL/TERM

COVERAGE ELECTIONS:	Add/Terminate	Coverage Requested	Effective Date
Basic Life		Amount $	
Optional Life (requires Basic Life)		Amount $	
Dependent Life (Flat Plan)		Bank Election	
Dependent Life - Spouse		Amount $	
Dependent Life - Child		Amount $	
MBA Long Term Disability			
MBA Short Term Disability		If Buy-up, weekly benefit $	

MBA DENTAL COVERAGE	Add/Terminate	Effective Date
☐ Employee Only		
☐ Employee Plus One		
☐ Employee and Family		

For **Dependent Coverage** please fill out dependent information immediately below

DEP. LIFE/DENTAL

DEPENDENT INFORMATION: Dental and Dependent Life (includes spouse & eligible dependent children) *See booklet

Life Add/Delete	Dental Add/Delete	Name	Relationship	Gender	Date of Birth Month/Day/Year
				M F	
				M F	
				M F	

LIFE ONLY

Beneficiary Information-New Enrollment/Change (Complete Only if Life Coverage is Selected)

I realize that this designation is effective on the date signed below and will override any previous designations. If more than one beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living unless their shares are specified. If no beneficiary is designated or if no designated beneficiary survives the insured, settlement will be made to the estate of the insured, unless otherwise provided in the Group Policy. Beneficiary designations are the same for both the Basic and Optional Insurance. Percentages may be reflected to separate or divide benefits.

Primary Beneficiary Name(s)	Relationship	Social Security No.	Date of Birth	% of Proceeds
				%
				%
				%
Contingent Beneficiary Name(s)	**Relationship**	**Social Security No.**	**Date of Birth**	**% of Proceeds**
				%
				%

I authorize payroll deductions, if applicable, and declare that, to the best of my knowledge, I have reviewed all relevant disclosures and the information on this form is complete and true.

SIGN

Date:	Signature of Employee:	Email Address:

8050 Washington Avenue South · Suite 150 · Eden Prairie, MN 55344 *Phone:* 952-835-3900 · *MN Toll Free:* 866-835-3900 · *Fax:* 952-896-1100 · www.minnbankers.com

Instructions

Check All That Apply
Place a check in the box that applies to the action you would like to take.

Required
The employee address is required for dental coverage. Earnings are required for all life and disability plans.

Waiver
You may only waive coverage if you pay a portion of the premium. If your bank pays the entire premium for a plan, coverage is mandatory and you must enroll in that plan. If you waive coverage, please make sure to sign & date the bottom of the form.

Enrollment/Termination
Reflect the plans you are electing based on the plans your employer offers. Dependent life-If your bank offers dependent life, you may have a predetermined flat benefit for your spouse/child. Alternatively, your bank may allow you to pick the increment amount of your spouse/children. Please check with your employer or the MBA Insurance department if you do not know your options.

Dependent Life/Dental
If your employer offers dependent life coverage, please list all dependents you would like insured. Also, if you have selected dental plus one or dental plus family, please make sure to list all dependents. You may attach another sheet if necessary.

Life Only
If your employer offers life coverage, please reflect your beneficiary designations in this section. Life insurance proceeds cannot be paid to a beneficiary who is a minor. If you want your minor children to receive your life insurance proceeds, please consult your legal advisor. In the event of a claim and no beneficiary has been selected, the pay order of the benefit is determined by the carrier as outlined in the plan booklet.

Sign
An employee signature is required (unless the action is due to termination)

Applicable to Life and Disability Coverage

Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.