INSTRUCTIONS FOR COMPLETING THE ACCIDENT PLAN APPLICATION

Please complete the application form to enroll for accident insurance. Premiums for this plan will be deducted through a payroll deduction.

- If you are enrolling in Employee coverage only, complete all fields in the employee information section.
- If you are enrolling in Employee + Spouse coverage, complete all fields in the Employee and Spouse sections.
- If you are enrolling in Employee + Child coverage, complete all fields in the Employee and Children sections.
- If you are enrolling in Employee + Family coverage, complete all fields in the Employee, Spouse and Children sections.
- Sign and date the application.
- RETURN the application to your HR/Payroll Specialist.
- Your election to enroll for coverage must be made within 30 days of your enrollment period.
- If you are not enrolling for the Accident Plan an application does not need to be submitted.

QUESTIONS: Contact your HR/Payroll specialist

Group Accident Insurance Enrollment

Securian Life Insurance Company
Group Customer Service
400 Robert Street North • St. Paul, Minnesota 55101-2098
Return to your Payroll Center ☐ received

EMPLOYER NAME: State of Wisconsin **POLICY NUMBER: 76038**

EMPLOYEE INFORMATION (always complete for coverage)

First name	Middle initial	Last name		Phone number

Street address	City	State	Zip code

Date of birth	Last 4 digits of SSN or EE ID	Date of employment	Email address

Amount of insurance elected

☒ Supplemental Plan

SPOUSE INFORMATION (only complete if you want coverage)

First name	Middle initial	Last name	Phone number

Date of birth	Email address

CHILDREN INFORMATION (only complete if you want coverage)

Child name	Date of birth	Child name	Date of birth

AUTHORIZATION

I understand that Securian Life Insurance Company shall incur no liability until the first premium is paid, and that premiums for the contributory insurance will be deducted from my pay. The information submitted is true and complete to the best of my knowledge and belief. I have reviewed all applicable eligibility requirements for the coverage(s) I have elected and certify all such requirements have been met.

Employee signature	Employee name (please print)	Date signed
X		