Dependent Life Insurance Coverage Election

Human Resources
Building 2455, Suite 221
3640 Colonel Glenn Hwy.
Dayton, OH 45435-0001
Tel: (937) 775-2120 Fax: (937) 775-3040

I hereby request voluntary dependent life insurance coverage under Wright State University's agreement with The Minnesota Life Insurance Company for the dependents named below.

Employee Information:

Last Name:	First Name, Middle Initial:	University ID:
Department:		Effective Date of Enrollment:

Coverage Selection:

Enroll the dependents named below in the term dependent life insurance coverage option I have selected here:	☐ Option 1: • $10,000.00 of protection for my spouse or domestic partner; • $2,000.00 of protection for each of my qualifying dependent children*	☐ Option 2: • $25,000.00 of protection for my spouse or domestic partner; • $10,000.00 of protection for each of my qualifying dependent children*

**Children are eligible from live birth up to age 19, or up to age 23 if a full-time student and is dependent on you for 50% or more of his or her support. Children age 19 and older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 19 (23 if a full-time student) and are financially dependent on you for more than one-half of their support and maintenance.*

Insured Dependent(s) Information:

Last Name:	First Name, Middle Initial:	Social Security Number:
Date of Birth:	Relationship to Employee: ☐ Spouse ☐ Domestic Partner ☐ Dependent Child	

Last Name:	First Name, Middle Initial:	Social Security Number:
Date of Birth:	Relationship to Employee: ☐ Dependent Child	

Last Name:	First Name, Middle Initial:	Social Security Number:
Date of Birth:	Relationship to Employee: ☐ Dependent Child	

Last Name:	First Name, Middle Initial:	Social Security Number:
Date of Birth:	Relationship to Employee: ☐ Dependent Child	

I certify that all information provided on this form is correct to the best of my knowledge and authorize release of any information requested by Wright State University or The Minnesota Life Insurance Company with respect to this Enrollment. I am aware that the premium associated with this coverage is based on the employee's age as of December 31st of the current plan year.

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Employee Signature ***Date***