Notification Date_____

APPLICATION FOR STATE CONTINUATION
OF LIFE COVERAGE (MINNESOTA)

Coverage applied for: (check one) _____ EMPLOYEE _____SPOUSE _____DEPENDENT

If Your Accidental Death & Dismemberment (AD&D) or Life Benefits end because of termination or temporary lay-off, and coverage remains in force for Actively at Work employees, You may choose to continue such coverage for yourself and Your Dependents for:

- up to 18 months; or
- until You become eligible for coverage under another group plan, whichever occurs first.

- For a Dependent, to the date they are no longer an Eligible Dependent.

If you choose to continue coverage, complete the information requested and return within 60 days from the date you receive this notice. Failure to elect within 60 days will forfeit your right to make an election at a later date.

EMPLOYEE NAME _____ GROUP ID NUMBER _____

EMPLOYEE SOCIAL SECURITY/ID_____ GROUP NAME (POLICYHOLDER) _____

BIRTH DATE _____ DATE OF TERMINATION/LAY-OFF _____

My right to continue AD&D/Life coverage is the result of: (check one)

_____1. Termination of employment, voluntary or involuntary (other than for "Gross Misconduct").
_____2. Temporary Lay-off.

I wish to continue the following coverages for which I am eligible.

COVERAGE (Example: AD&D, Life)	INDICATE SINGLE OR FAMILY
1. _____	1. _____
2. _____	2. _____

I elect **TO CONTINUE** group AD&D and/or Life coverage, as indicated above, and I understand that this coverage will not remain in force if the premium is not paid by me when due to the above named Policyholder.

_____ _____
Signature of Applicant Date Signed

VERY IMPORTANT NOTICE: You are not eligible for continuation of coverage if you are now covered or become covered under any other group plan (i.e. your spouse's plan). You may elect continuation of coverage and make payment of the required premium to the Policyholder within 60 days from the date of termination or lay off, or the date You receive this notice of the right to continue coverage, whichever is later.

If you fail to make the monthly payment to the Policyholder when due, your coverage will cease at the end of the period for which payment has been made subject to the grace period provisions of the plan and cannot be reinstated.

G457-88/3-23/MN

RETURN THIS FORM TO EMPLOYER