

# Optional Group Life Insurance

*Virginia Retirement System*



**Protect your family and  
your way of life**

*Underwritten by  
Minnesota Life*

**MINNESOTA LIFE**



## Life insurance: Providing a safety net for your family's financial security

**Y**ou work hard to provide for your family. Your Virginia Retirement System (VRS) benefits help you to ensure future financial security for your loved ones. One way to make sure your family is able to meet financial obligations and fulfill future dreams is through life insurance. As a member of the VRS, you have the opportunity to protect your family's financial security with optional group life insurance. This term insurance program is designed to provide an immediate death benefit at an affordable cost.

### Optional Life insurance: How much insurance is available?

The VRS Optional Group Life insurance program provides an opportunity to purchase additional life insurance protection at attractive group rates. You can select coverage on yourself for an additional one, two, three or four times your salary (rounded to the next highest \$1,000), up to a maximum of \$600,000.

	Employee	Spouse	Children
Option	Insurance amount	Insurance amount	15 days to maximum age
1	1 x salary	.5 x Employee salary	\$10,000
2	2 x salary	1 x Employee salary	\$10,000
3	3 x salary	1.5 x Employee salary	\$20,000
4	4 x salary	2 x Employee salary	\$30,000



Each option outlines the amount of coverage a member and the family receives.

- As an employee, you may select coverage options for one, two, three or four times your salary (rounded to the next highest \$1,000), up to a maximum of \$600,000.
- Your spouse can apply for half of the amount of your coverage, up to a maximum of \$300,000.
- Children's coverage is based on the option the employee selects. The amount of insurance covers each eligible child.

### Added benefits enhance your protection

Optional Life insurance also includes the following benefits:

- **A double indemnity benefit.** An additional benefit equal to the amount of optional coverage in force is paid, if death is a result of a covered accident.
- **A dismemberment benefit** that pays you an amount equivalent to either one-half or the full amount of the insurance, if you lose sight or suffer a severed limb as a result of an accident.
- **A living benefit.** The accelerated benefit allows the insured person to receive all or a portion of the death benefit, if diagnosed with a terminal illness with a life expectancy of 12 months or less.

## How much life insurance do you need?

Everyone's financial protection needs are different, but the factors to consider are not.

Think about what your dependents would have if you were to die now, and what they would actually need. What resources and obligations would your family have if you were no longer around?

First, look at your assets. This list may include your VRS Basic insurance, along with other insurance, your investments, savings, real estate and personal property. Then compare this to your liabilities, including daily living expenses, mortgage and other loans, tax payments and education costs.

Use the handy tool, "How much life insurance do you need?," to help you determine your financial needs.

If your family is growing or you have many financial obligations, increasing your life insurance may be the answer to meeting your family's future financial needs.

Say you are a young person just starting a family. Your assets from savings and investments may be lower because you've had less time to accumulate them. Life insurance may be helpful in meeting a future commitment to educating your children and other college expenses.

At the same time, if you're successful and enjoying the fruits of your labor, additional life insurance can help meet the financial obligations of a mortgage or other loans to maintain your family's standard of living.



## How much life insurance do you need?

How long do you wish to provide financial support to your family? \_\_\_\_\_ months

How much would your family need for housing expenses — to pay off the mortgage or continue the rent? (Number of months x monthly housing expenses.) +\$ \_\_\_\_\_

How much would your children need to pay for their education? +\$ \_\_\_\_\_

How much would your family need to pay for all other installment debt — car payments, credit cards, personal loans? (Number of months x monthly installment debt.) +\$ \_\_\_\_\_

How much would your family need to meet ongoing expenses — food, utilities and day care? (Number of months x average monthly expenses.) +\$ \_\_\_\_\_

**Total:** \$ \_\_\_\_\_

Subtract the amount of any Social Security, personal savings, life insurance or other benefits you already have in place. -\$ \_\_\_\_\_

Consider adding this amount of life insurance: \$ \_\_\_\_\_

*Note: To cover personal debts and fund other expenses, your individual financial situation may require more or less insurance than this worksheet suggests.*

## How much does it cost?

The VRS Optional Group Life insurance program provides additional life insurance protection at attractive group rates. Premiums for the employee and the spouse are based on the age of the insured person. The rates shown are for each \$1,000 of insurance.

Employee and spouse rates	
Age	Monthly rates per \$1,000
Under 30	\$0.05
30 - 34	0.07
35 - 39	0.08
40 - 44	0.09
45 - 49	0.14
50 - 54	0.22
55 - 59	0.43
60 - 64	0.66
65 - 69	1.27
70 - 74	2.06
75 and over	2.06

## Child(ren) rates

One premium covers all children; there is no per-child rate.

Option	Insurance amount 15 days to maximum age	Flat monthly rate
1	\$10,000	\$0.80
2	\$10,000	\$0.80
3	\$20,000	\$1.60
4	\$30,000	\$2.40

## Who are the beneficiaries for Optional Life?

Because the beneficiaries of an employee's Optional Life insurance are generally the same as those designated for the VRS Basic Group Life insurance, you can be sure your loved ones will receive this added protection.

The employee is the beneficiary of the spouse and the children's Optional Life coverage.

## How do I apply for Optional Life?

Just complete the Enrollment Application (VRS-39) contained in this pamphlet and send it — if applicable — with the completed Evidence of Insurability form (VRS-32) to P.O. Box 1193, Richmond, VA 23218-1193.

If you apply for Optional Life within 31 days from the date of employment, you may receive all options, up to a maximum death benefit of \$300,000, without providing evidence of good health.

If you select an option that provides more than \$300,000 of coverage, you'll be required to submit an Evidence of Insurability form (VRS-32). Until coverage is approved, your coverage will be limited to the amount of the next-lowest option, not exceeding \$300,000.

Likewise, your spouse is guaranteed for Option 1 (one-half of your salary) if he or she applies within 31 days after you first become eligible for Optional Life coverage. If you select Option 2, 3 or 4, your spouse will be asked to furnish evidence of insurability for Minnesota Life's approval before he or she will be covered. If the evidence of insurability is not approved, your spouse will continue to be insured for the amount provided under Option 1 (one-half of your salary).

If both you and your spouse are eligible for Optional Life as employees, you may not elect spouse coverage. Likewise, either you or your spouse, not both, may elect coverage for your children.

Child(ren) will receive coverage at the level corresponding to the option you select. Children's coverage also does not require proof of insurability, if coverage is applied for within 31 days of them becoming eligible to be insured.

Application for Optional Life may also be made at any time beyond 31 days after either the employment date or eligibility date. Additional enrollment forms are also available through your benefits administrator or from Minnesota Life. Minnesota Life's address is P.O. Box 1193, Richmond, VA 23218-1193. Or call 1-800-441-2258.



## Will I be able to continue my Optional Life insurance when I retire?

You may continue your Optional Life insurance if you are:

- retiring.
- Terminating service, but deferring retirement.

You must have 60 months of coverage with Optional Life before leaving service. You'll pay the same premiums to continue your coverage as active employees do.

As a retiree, you may continue at either Option 1 or Option 2, but not more than the amount of insurance you had when you left service, and not more than \$200,000. You must elect to continue coverage within 31 days of leaving service. Optional coverage above these amounts may be converted to an individual policy. Insurance amounts and the corresponding maximums begin to reduce at age 65 and all insurance terminates at age 80.

Spouse coverage may also continue at the corresponding Option 1 and Option 2 levels of insurance selected by the retiree. Insurance on the spouse continues to be one-half of the amount of the retiree's coverage. Premium is based on the same rates under the VRS group plan. Dependent children may continue to be insured by the retiree at the same levels previously insured prior to retirement.

## What happens if I terminate employment?

If you terminate employment and are not eligible to continue Optional Life coverage as a retiree, your Optional Life insurance terminates. However, you may convert to an individual policy. The conversion privilege may be exercised without proof of insurability, if election to convert is made within 31 days of the termination.

Spouse and dependent children coverage also ends when your coverage terminates, but you may also convert this insurance to an individual policy.



**MINNESOTA LIFE**

**ENROLLMENT APPLICATION FOR VRS  
OPTIONAL GROUP LIFE INSURANCE**

Minnesota Life Insurance Company • Richmond Branch Office • P.O. Box 1193 • Richmond VA 23218-1193

EMPLOYER CODE (5 DIGITS)	EMPLOYER NAME	EMPLOYEE'S ANNUAL SALARY \$
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**1 - EMPLOYEE INFORMATION**

SOCIAL SECURITY NUMBER	EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)				
STREET ADDRESS		CITY	STATE	ZIP CODE	
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	AGE	DATE OF BIRTH (MO./DAY/YR.)	EMPLOYMENT DATE (MO./DAY/YR.)	PAYROLL FREQUENCY

**2 - ELECTION OF INSURANCE AMOUNTS**

I wish to insure myself  and  my spouse and  my child(ren).

Sign and date section 4, Payroll Deduction Authorization. (If you do not elect to be insured under the VRS Optional Plan you must complete section 5 below.)

**OPTIONAL INSURANCE AMOUNTS**

Option	Employee	Spouse	Child(ren)
<input type="checkbox"/> 1	1 X Salary	.5 X Salary	\$ 10,000
<input type="checkbox"/> 2	2 X Salary	1.0 X Salary	\$ 10,000
<input type="checkbox"/> 3	3 X Salary	1.5 X Salary	\$ 20,000
<input type="checkbox"/> 4	4 X Salary	2.0 X Salary	\$ 30,000

If the option you elected will provide insurance of \$300,000 or higher, you must complete an Evidence of Insurability form (EOI). Your spouse must also complete an EOI form if you elected options 2,3, or 4. Optional amounts of insurance in excess of \$600,000 for an employee and \$300,000 for a spouse are not provided. If you and your spouse are insured as employees under the Basic VRS Group Life insurance plan neither of you is eligible for coverage as a spouse. If you do not apply when you are first eligible to do so, or within 31 days immediately thereafter, you must complete an EOI for yourself and eligible dependents you subsequently elect to insure.

**3 - DEPENDENT INFORMATION**

See reverse side for definition of Eligible Dependents (eligibility must be verified by Employer's Representative.)

How many children do you have who are less than 21 years of age? \_\_\_\_\_

How many children do you have who are age 21 to 25 and who are currently full-time students? \_\_\_\_\_

List information about your spouse and **youngest** child below:

First	Name MI	Last	Relationship	Sex M or F	Social Security Number	Date of Birth Month Day Year
			Your Spouse			
			Youngest Child			

**4 - PAYROLL DEDUCTION AUTHORIZATION**

I hereby authorize my Employer to deduct from my compensation the amount necessary to provide the insurance amounts indicated above. I understand that the deduction amount will change as my age and annual salary change.

SIGNATURE X	DATE SIGNED
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**5 - WAIVER OF COVERAGE**

I **DO NOT** wish to enroll for myself or for my eligible dependents in the VRS Optional Insurance Plan. I understand that once coverage is waived, I will have to furnish evidence of insurability for myself and eligible dependents if I wish to become insured at a later date.

SIGNATURE X	DATE SIGNED
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**6 - STATEMENT BY EMPLOYER'S REPRESENTATIVE**

I certify that I believe the statements made herein are true and accurate, as disclosed by the records of this office, and the Social Security Number and Annual Salary are correct as entered.

EMPLOYER'S REPRESENTATIVE X	TITLE	DATE SIGNED
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**7 - REPLACEMENT INSURANCE INFORMATION**

YES WILL THE INSURANCE YOU ARE APPLYING FOR REPLACE OR CHANGE AN EXISTING POLICY? IF YES, PLEASE COMPLETE THE  
 NO REPLACEMENT FORM.

APPLICANT SIGNATURE X	DAYTIME TELEPHONE NUMBER ( )	DATE SIGNED
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**FOR HOME OFFICE USE**

AGENT/BROKER/REGISTERED REPRESENTATIVE	AGENT: To the best of my knowledge and belief, will the insurance applied for replace or change an existing policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
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AGENT'S SIGNATURE X	DATE SIGNED
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**ELIGIBLE DEPENDENTS**

The following persons are eligible to be insured under the VRS Optional Group Life Insurance Plan:

- the employee's spouse, and
- the employee's unmarried, natural, or legally adopted children\* who are not self-supporting, and
- the employee's unmarried step-children\* who live full-time with the employee in a parent-child relationship and can be claimed as a dependent on the employee's Federal income tax return, and
- any other children\* if they are in the permanent court-ordered custody of the employee.

\* less than 21 years of age (age 25 if a full-time college student).

**Beneficiary Information**

The employee's beneficiary for Optional Group Life Insurance is the same as designated for the employee's Basic VRS Group Insurance. The employee is the beneficiary for the Optional Group Life Insurance on the employee's spouse and children.



**MINNESOTA LIFE**

**GROUP LIFE INSURANCE  
EVIDENCE OF INSURABILITY**

Minnesota Life Insurance Company • Richmond Branch Office • P.O. Box 1193 • Richmond VA 23218-1193

**EMPLOYER INFORMATION**

POLICYHOLDER NAME <b>Virginia Retirement System</b>		POLICY NUMBER <b>29414-G</b>
EMPLOYEE NAME	DATE OF BIRTH (MO./DAY/YR.)	SOCIAL SECURITY NUMBER
EMPLOYER NAME		EMPLOYER CODE

**APPLICANT INFORMATION**

APPLICANT NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH (MO./DAY/YR.)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT	WEIGHT
EMPLOYEE'S ANNUAL SALARY \$	SELECT ONE <input type="checkbox"/> OPTION 1 <input type="checkbox"/> OPTION 2 <input type="checkbox"/> OPTION 3 <input type="checkbox"/> OPTION 4		

**HEALTH QUESTIONS**

YES NO

- 1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
- 2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
- 3. Have you ever been diagnosed as having AIDS, or any disorder of your immune system; or had any test showing evidence of antibodies to the AIDS virus (a positive HIV test)?

If your answer to questions 1, 2 or 3 is yes, give particulars including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment below. Use the reverse side if additional space is needed.

The answers provided on this application are representations of the person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

To determine my insurability or for claim purposes, I authorize any person(s), medical practitioner, institution, insurance company or Medical Information Bureau (MIB) to give any medical or nonmedical information about me including alcohol or drug abuse, to the Company and its reinsurers. I authorize all said sources, except MIB, to give such information to any agency employed by the Company to collect and transmit such information. I understand in determining eligibility for insurance or benefits, this information may be made available to underwriting, claims, medical and support staff of the Company. This authorization is valid for 26 months or the duration of a claim, whichever is less. A photocopy shall be as valid as the original. I've read this and the Consumer Privacy Notice on the reverse side of this form, and I understand that I or my authorized representative can have copies.

APPLICANT SIGNATURE (OR EMPLOYEE SIGNATURE FOR CHILD) <b>X</b>	DAYTIME TELEPHONE NUMBER ( )	DATE SIGNED
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**CONSUMER PRIVACY NOTICE**

In addition to the information requested on this application, the Company may ask for the following: an insurance medical exam or laboratory tests; medical records from your physician, hospital, or your insurance company; an investigative consumer report; a report from the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

The Company or its reinsurer may make a brief report of this information to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file.

The Company may also send information about you to the following persons or organizations without your permission: to insurance organizations, for statistical studies, without identifying you; to a government agency involved in regulation of insurance; to your physician (the results of your insurance exam).

You have certain rights in connection with this insurance application. You have the right to: find out what personal

information is contained in the Company or MIB files; correct or amend information in the Company or MIB files; know the specific reasons why coverage is not issued.

At your request, the Company will explain in writing how you can exercise your right to learn what is in your file, how to correct or amend it, or how to find out why coverage is not issued.

**For further information about your file or your rights, you may contact:**

Group Division Underwriting  
 Minnesota Life Insurance Company  
 400 Robert Street North  
 St. Paul, Minnesota 55101-2098

**For information about the Medical Information Bureau, you may contact:**

Medical Information Bureau Information Office  
 P.O. Box 105, Essex Station  
 Boston, Massachusetts 02112  
 (MIB telephone number: (617) 426-3660)

**ADDITIONAL HEALTH INFORMATION:**

DATE	NAME, ADDRESS AND PHONE NUMBER OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

FOR HOME OFFICE USE ONLY:			
Applicant			
CURRENT IN FORCE \$	U/W APPLIED FOR \$	AMOUNT OF INSURANCE \$	SUBMITTED FOR <input type="checkbox"/> EXCESS AMOUNT <input type="checkbox"/> LATE ENTRANT
<input type="checkbox"/> APPR'D <input type="checkbox"/> DECL. <input type="checkbox"/> INCOM.			BY DATE



*This coverage is offered under policy  
form series 98-30001 or 98-30002.*

## **MINNESOTA LIFE**

**Minnesota Life Insurance Company**  
A Securian Financial Group Affiliate

**Group Insurance - Richmond Office**  
P.O. Box 1193  
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