

SERFF Tracking Number: MNNL-127117660 State: Arkansas  
Filing Company: Minnesota Life Insurance Company State Tracking Number: 48735  
Company Tracking Number: PJM-492  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Group Universal Life Insurance  
Project Name/Number: GUL 2 (2011 App, Actuarial Memorandum & MVT)/PJM-492

## Filing at a Glance

Company: Minnesota Life Insurance Company

Product Name: Group Universal Life Insurance SERFF Tr Num: MNNL-127117660 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 48735  
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: PJM-492

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Joy Norquist, Paula Moris, Disposition Date: 05/16/2011  
Teresa Guindon

Date Submitted: 05/10/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: 06/01/2011

Implementation Date:

State Filing Description:

## General Information

Project Name: GUL 2 (2011 App, Actuarial Memorandum & MVT)

Status of Filing in Domicile: Pending

Project Number: PJM-492

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 05/16/2011

State Status Changed: 05/16/2011

Deemer Date:

Created By: Paula Moris

Submitted By: Paula Moris

Corresponding Filing Tracking Number:

Filing Description:

11-31332.3 Group Universal Life Employee Application (with health questions)

11-31333.3 Group Universal Life Spouse Application (with health questions)

11-31334.3 Group Universal Life Spouse Application

11-31335.3 Group Universal Life Employee Application

Copies of the above-referenced Group Universal Life application form series are enclosed for your consideration and approval. These forms are new and will not replace any previously approved Group Universal Life forms approved for use in your state.

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These forms are intended for general use in the employer, multi-employer and labor union markets.

Enclosed is a Manual of Variable Text (MVT) which explains all variability on the application forms.

Also, for informational purposes only, we would like to make the following revisions:

- Enclosed is a revised Actuarial Memorandum and Manual of Variable Text. The revised Actuarial Memorandum will replace the Actuarial Memorandum filed in 2008 to update our tables in order to comply with 2001 CSO. The revised Manual of Variable Text will replace the Manual of Variable Text filed in conjunction with our Group Universal Life Policy form series 00-30252.3 et al, previously approved by the Department on February 15, 2001. The revised Actuarial Memorandum and Manual of Variable Text will apply to new business only that will become effective upon your acknowledgement and approval of this filing submission. The enclosed Actuarial Memorandum is being revised to allow us to change the minimum interest rate credited on the general account value to 1.5% annually.

There are three sections of the enclosed Manual of Variable Text being revised in relation to the changing the minimum interest rate credited to the general account value, as well as having the flexibility to change the interest rate payable on the death benefit.

The sections are on page 3 of the MVT under:

- The 3% minimum interest rate under "When will the death benefit be payable?"
- References to 3% interest in "What is the account value of a certificate?"

and under page 7 under:

- The reference to 3% in "When will an accidental death and dismemberment benefit be payable?"

In no event will the minimum interest rate decrease less than the state mandated requirements.

The above mentioned revisions are highlighted in the enclosed revised Manual of Variable Text.

- We are also enclosing a revised Manual of Variable Text for our Accidental Death and Dismemberment (AD&D) rider form number 06-30882, and certificate supplement form number 06-30883 which was previously approved by the Department on June 22, 2007 for use with all our previously approved life products. This manual of variable text is being revised in relation to having the flexibility to increase or decrease the interest rate on the accidental death & dismemberment benefit.

In no event will the minimum interest rate decrease less than the state mandated requirements.

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The revision made has been highlighted in the enclosed revised Manual of Variable Text.

In addition, we are requesting additional authority for our Group Life Insurance Evidence of Insurability form 03-30567.3 to be used with our Group Universal Life policy form series mentioned above. Our Group Life Insurance Evidence of Insurability form 03-30567.3, to be used with our Group Term Life Product, was previously approved by your Department on February 13, 2004. Upon approval this form will be will not be replacing any previously approved forms.

We request the Department's approval of these new application forms for use in the state of Arkansas.

Thank you for your attention to this filing submission. Should you have any questions with regard to this filing, please feel free to contact me.

## Company and Contact

### Filing Contact Information

Paula Moris, Sr. Product Compliance Specialist paula.moris@securian.com  
 400 Robert Street North 651-665-1273 [Phone]  
 St. Paul, MN 55101-2098 651-665-5424 [FAX]

### Filing Company Information

|                                  |                         |                              |
|----------------------------------|-------------------------|------------------------------|
| Minnesota Life Insurance Company | CoCode: 66168           | State of Domicile: Minnesota |
| 400 Robert Street North          | Group Code: 869         | Company Type:                |
| Law Department                   | Group Name:             | State ID Number:             |
| St. Paul, MN 55101-2098          | FEIN Number: 41-0417830 |                              |
| (651) 665-3500 ext. [Phone]      |                         |                              |

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## Filing Fees

|                  |  |
|------------------|--|
| Fee Required?    | Yes  |
| Fee Amount:      | \$125.00   |
| Retaliatory?     | Yes  |
| Fee Explanation: | Arkansas is a retaliatory state. In Arkansas filing fees are \$20.00 per life insurance form . We are submitting 5 application forms. 5 X \$20.00 = \$100.00. The filing fee for life insurance forms filed in the state of Minnesota, which is the state of domicile, is a flat \$125.00. |

The filing fee charged in the domiciliary state of Minnesota is greater.  
 Per Company: No

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| COMPANY                          | AMOUNT   | DATE PROCESSED | TRANSACTION # |
|----------------------------------|----------|----------------|---------------|
| Minnesota Life Insurance Company | \$125.00 | 05/10/2011     | 47429205      |

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## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 05/16/2011 | 05/16/2011     |
| Approved-Closed | Linda Bird | 05/16/2011 | 05/16/2011     |

### Objection Letters and Response Letters

| Objection Letters         |            |            |                | Response Letters |            |                |
|---------------------------|------------|------------|----------------|------------------|------------|----------------|
| Status                    | Created By | Created On | Date Submitted | Responded By     | Created On | Date Submitted |
| Pending Industry Response | Linda Bird | 05/16/2011 | 05/16/2011     | Paula Moris      | 05/16/2011 | 05/16/2011     |

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## **Disposition**

Disposition Date: 05/16/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MNNL-127117660 State: Arkansas  
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 Project Name/Number: GUL 2 (2011 App, Actuarial Memorandum & MVT)/PJM-492

| Schedule            | Schedule Item                            | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification                     |                      | Yes           |
| Supporting Document | Application                              |                      | No            |
| Supporting Document | Manual of Variable Text for Applications |                      | Yes           |
| Supporting Document | For Informational Purposes - Revised     |                      | No            |
|                     | Supporting Documentation                 |                      |               |
| Form                | Group Universal Life Employee            |                      | Yes           |
|                     | Application (with health questions)      |                      |               |
| Form                | Group Universal Life Spouse Application  |                      | Yes           |
|                     | (with health questions)                  |                      |               |
| Form                | Group Universal Life Spouse Application  |                      | Yes           |
| Form                | Group Universal Life Employee            |                      | Yes           |
|                     | Application                              |                      |               |

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## **Disposition**

Disposition Date: 05/16/2011

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| Schedule            | Schedule Item  | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification   |                      | Yes           |
| Supporting Document | Application  |                      | No            |
| Supporting Document | Manual of Variable Text for Applications                             |                      | Yes           |
| Supporting Document | For Informational Purposes - Revised<br>Supporting Documentation     |                      | No            |
| Form                | Group Universal Life Employee<br>Application (with health questions) |                      | Yes           |
| Form                | Group Universal Life Spouse Application<br>(with health questions)   |                      | Yes           |
| Form                | Group Universal Life Spouse Application                              |                      | Yes           |
| Form                | Group Universal Life Employee<br>Application                         |                      | Yes           |

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## Objection Letter

|                         |                           |
|-------------------------|---------------------------|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date   | 05/16/2011                |
| Submitted Date          | 05/16/2011                |
| Respond By Date         | 06/16/2011                |

Dear Paula Moris,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: Filing was approved in error. The Applications were not listed on the Form Schedule.

Please feel free to contact me if you have questions.

Sincerely,  
Linda Bird

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 05/16/2011  
 Submitted Date 05/16/2011

Dear Linda Bird,

### Comments:

This is in response to the Department's May 16, 2011 correspondence informing us the applications were not listed on the Form Schedule.

### Response 1

Comments: The applications, have been added to the forms schedule.

### Related Objection 1

Comment:

Filing was approved in error. The Applications were not listed on the Form Schedule.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

| Form Name   | Form Number | Edition Date | Form Type                   | Action  | Action Specific Data | Readability Score | Attach Document                      |
|---|-------------|--------------|-----------------------------|---------|----------------------|-------------------|--------------------------------------|
| Group Universal Life Employee Application (with health questions) | 11-31332.3  |              | Application/Enrollment Form | Initial |                      |                   | 11-31332.3 EE App JDoe_4-18-2011.pdf |
| Group Universal Life Spouse Application (with health questions)   | 11-31333.3  |              | Application/Enrollment Form | Initial |                      |                   | 11-31333.3 Spouse App                |

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|                      |         |                        |         |  |                    |
|----------------------|---------|------------------------|---------|--|--------------------|
|                      |         |                        |         |  | JDoe_4-18-2011.pdf |
| Group Universal Life | 11-     | Application/Enrollment | Initial |  | 11-                |
| Spouse Application   | 31334.3 | Form                   |         |  | 31334.3            |
|                      |         |                        |         |  | EE App             |
|                      |         |                        |         |  | JDoe_no            |
|                      |         |                        |         |  | health             |
|                      |         |                        |         |  | questions          |
|                      |         |                        |         |  | _4-18-             |
|                      |         |                        |         |  | 2011.pdf           |
| Group Universal Life | 11-     | Application/Enrollment | Initial |  | 11-                |
| Employee Application | 31335.3 | Form                   |         |  | 31335.3            |
|                      |         |                        |         |  | Spouse             |
|                      |         |                        |         |  | App                |
|                      |         |                        |         |  | JDoe_no            |
|                      |         |                        |         |  | health             |
|                      |         |                        |         |  | questions          |
|                      |         |                        |         |  | _4-18-             |
|                      |         |                        |         |  | 2011.pdf           |

No Rate/Rule Schedule items changed.

Thank you for bringing this to my attention, and I apologize for any inconvenience this error may have caused.

Sincerely,  
 Joy Norquist, Paula Moris, Teresa Guindon

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## Form Schedule

### Lead Form Number: 11-31332

| Schedule Item Status | Form Number | Form Type                   | Form Name   | Action  | Action Specific Data | Readability | Attachment   |
|----------------------|-------------|-----------------------------|---|---------|----------------------|-------------|--|
|                      | 11-31332.3  | Application/Enrollment Form | Group Universal Life Employee Application (with health questions) | Initial |                      |             | 11-31332.3<br>EE App<br>JDoe_4-18-2011.pdf                         |
|                      | 11-31333.3  | Application/Enrollment Form | Group Universal Life Spouse Application (with health questions)   | Initial |                      |             | 11-31333.3<br>Spouse App<br>JDoe_4-18-2011.pdf                     |
|                      | 11-31334.3  | Application/Enrollment Form | Group Universal Life Spouse Application                           | Initial |                      |             | 11-31334.3<br>EE App<br>JDoe_no health questions_4-18-2011.pdf     |
|                      | 11-31335.3  | Application/Enrollment Form | Group Universal Life Employee Application                         | Initial |                      |             | 11-31335.3<br>Spouse App<br>JDoe_no health questions_4-18-2011.pdf |

# Group Universal Life Employee Application

# MINNESOTA LIFE

Minnesota Life Insurance Company – A Securian Company  
400 Robert Street North • B2-4256 • St. Paul, Minnesota 55101-2098

**[EMPLOYER:] [ABC Company]**

**[POLICY NUMBER:] [12345-G]**

## **[INSURED'S INFORMATION (insured is the owner of the insurance unless otherwise requested)]**

|                                       |                                      |   |  |
|---------------------------------------|--------------------------------------|---|--|
| [Employee name]<br>[John C. Doe]      | [Date of birth]<br>[01/10/1975]      | [Social Security number]<br>[123-45-6789] | [Gender]<br><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female |
| [Street address]<br>[456 Main Street] | [City]<br>[Anytown]                  | [State]<br>[USA]                          | [Zip code]<br>[00000]  |
| [Email address]<br>[j.doe@work.com]   |                                      |   |  |
| [Occupation]<br>[computer programmer] | [Date of employment]<br>[01/01/2010] | [Annual salary]<br>[\$100,000]            | [Payroll frequency]<br>[Monthly]   |

Yes  No Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form?

Yes  No On the date you sign this application, are you actively working at your employer's normal place of business at least [20] hours per week?

|   |   |   |
|---|---|---|
| [Primary beneficiary designation (include full name and address)]<br><br>[Jane A. Doe]  | [Relationship]<br><br>[Spouse]            | [Share % (must total 100%)]<br><br>[100%]         |
| [Contingent beneficiary designation (include full name and address) <i>Contingent Beneficiaries collect only if all Primary Beneficiaries predecease the insured.</i> ]<br><br>[Sally B. Doe]<br>[Joe C. Doe] | [Relationship]<br><br>[Daughter]<br>[Son] | [Share % (must total 100%)]<br><br>[50%]<br>[50%] |

## **[INSURANCE INFORMATION]**

**[If applying for more than the guaranteed issue amount, you must complete the Health Questions on the next page.]**

|   |
|---|
| [Amount of automatic coverage ]<br><input checked="" type="checkbox"/> \$[10,000]   |
| [Amount of elected coverage ]<br><input type="checkbox"/> waive <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input checked="" type="checkbox"/> 4x <input type="checkbox"/> 5x <input type="checkbox"/> 6x <input type="checkbox"/> 7x <input type="checkbox"/> 8x <input type="checkbox"/> 9x <input type="checkbox"/> 10x annual salary |
| [Accidental death and dismemberment insurance requested]<br><input type="checkbox"/> waive <input checked="" type="checkbox"/> yes (matches the amount selected above)  |
| [Amount of monthly contribution to the cash accumulation account]<br><input type="checkbox"/> waive <input checked="" type="checkbox"/> \$[100.00]  |
| [Spouse term life rider]<br><input type="checkbox"/> waive <input checked="" type="checkbox"/> \$[50,000]   |
| [Child term coverage]<br><input type="checkbox"/> waive <input checked="" type="checkbox"/> \$[10,000]  |

**[If you applied for spouse or child term insurance, please enter the information below:**

|                                |                               |  |                               |
|--------------------------------|-------------------------------|--|-------------------------------|
| Spouse's name<br>[Jane A. Doe] | Date of birth<br>[02/28/1980] | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form? |                               |
| Child's name<br>[Joe C. Doe]   | Date of birth<br>[06/01/2006] | Child's name<br>[Sally B. Doe]   | Date of birth<br>[01/18/2004] |
| Child's name                   | Date of birth                 | Child's name   | Date of birth                 |

**[Please sign back of form →]**

**HEALTH QUESTIONS [(must be answered for coverage that is not guaranteed)]**

|  |  |  |  |
|--|--|--|--|
| [Employee]<br>[Yes] [No]                                     | [Spouse]<br>[Yes] [No]                                       | [Employee]<br>[Height] [5'11"] [Weight] [175]  | [Spouse]<br>[Height] [5'0"] [Weight] [125] |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input checked="" type="checkbox"/> | (1) During the past three years, have you for any reason consulted a physician(s) or other health care provider(s) or been hospitalized?   |  |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input checked="" type="checkbox"/> | (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? |  |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | <input type="checkbox"/> <input checked="" type="checkbox"/> | (3) Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (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 you answer yes to any question, please provide details below or on a separate sheet of paper.

| [Name] | [Date] | [Name and address of doctor, clinic or hospital] | [Reason for consultation] | [Diagnosis and treatment] |
|--------|--------|--|---------------------------|---------------------------|
|        |        |  |                           |                           |

**CONSUMER PRIVACY NOTICE**

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

**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  
Telephone: [800-872-2214]

**For information about the MIB, you may contact:**

MIB  
50 Braintree Hill, Suite 400  
Braintree, MA 02184-8734  
MIB Telephone: (866) 692-6901  
MIB TTY: (866) 346-3642  
Website: www.mib.com

**[AUTHORIZATION]**

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. If I do not revoke this authorization, it will be valid for 24 months from the date I sign it. A photocopy shall be as valid as the original. I have read this Authorization and the Consumer Privacy Notice on the second page and I understand that I can have copies.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

|   |  |  |                               |
|---|--|--|-------------------------------|
| [Employee signature]<br>X [ /s/ John C. Doe ] | [Daytime phone number]<br>[(111) 222-3333] | [Evening phone number]<br>[(111) 222-4444] | [Date signed]<br>[03-01-2011] |
| [Spouse signature]<br>X [ /s/ Jane A. Doe ]   | [Daytime phone number]<br>[(111) 222-3333] | [Evening phone number]<br>[(111) 222-4444] | [Date signed]<br>[03-01-2011] |

**[FOR HOME OFFICE USE ONLY:]****[POLICY NUMBER: 123456]**

| [Employee]   |                   |                 | [Spouse]   |                   |                 | [Children]   |                   |                 |
|--|-------------------|-----------------|--|-------------------|-----------------|--|-------------------|-----------------|
| [Current in force]   | [U/W applied for] | [Total elected] | [Current in force]   | [U/W applied for] | [Total elected] | [Current in force]   | [U/W applied for] | [Total elected] |
| [\$ 0.00 ]   | [\$50,000 ]       | [\$ 50,000 ]    | [\$ 0.00 ]   | [\$ 50,000 ]      | [\$ 50,000 ]    | [\$ 0.00 ]   | [\$ 10,000 ]      | [\$ 10,000 ]    |
| <input checked="" type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Incomplete |                   |                 | <input checked="" type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Incomplete |                   |                 | <input checked="" type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Incomplete |                   |                 |
| [By]<br>[ /s/ Joe Underwriter ]  |                   |                 |  |                   |                 | [Date]<br>[04-01-2011]   |                   |                 |

# Group Universal Life Spouse Application

MINNESOTA LIFE

Minnesota Life Insurance Company – A Securian Company  
400 Robert Street North • B2-4256 • St. Paul, Minnesota 55101-2098

**[EMPLOYER:] [ABC Company]**

**[POLICY NUMBER:] [12345-G]**

## EMPLOYEE INFORMATION

|                                       |                                 |   |  |
|---------------------------------------|---------------------------------|---|--|
| [Employee name]<br>[John C. Doe]      | [Date of birth]<br>[01/10/1975] | [Social Security number]<br>[123-45-6789] | [Gender]<br><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female |
| [Street address]<br>[456 Main Street] | [City]<br>[Anytown]             | [State]<br>[USA]                          | [Zip code]<br>[00000]  |

## SPOUSE INFORMATION (spouse is the owner of the insurance unless otherwise requested)

|   |                                 |   |  |
|---|---------------------------------|---|--|
| [Spouse name]<br>[Jane A. Doe]  | [Date of birth]<br>[02/28/1980] | [Social Security number]<br>[912-34-5678] | [Gender]<br><input type="checkbox"/> Male <input checked="" type="checkbox"/> Female |
| [Street address (check here if same as above <input checked="" type="checkbox"/> )] | [City]                          | [State]                                   | [Zip code]   |
| [Email address]<br>[j.doe@work.com]   | [Occupation]<br>[nurse]         |   |  |

Yes  No Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form?

|  |                            |                                       |
|--|----------------------------|---------------------------------------|
| [Primary beneficiary designation (include full name and address)]<br>[John C. Doe] | [Relationship]<br>[Spouse] | [Share % (must total 100%)]<br>[100%] |
|--|----------------------------|---------------------------------------|

|   |                                       |   |
|---|---------------------------------------|---|
| [Contingent beneficiary designation (include full name and address) <i>Contingent Beneficiaries collect only if all Primary Beneficiaries predecease the insured.</i> ]<br>[Sally B. Doe]<br>[Joe C. Doe] | [Relationship]<br>[Daughter]<br>[Son] | [Share % (must total 100%)]<br>[50%]<br>[50%] |
|---|---------------------------------------|---|

## INSURANCE INFORMATION

**[If applying for more than the guaranteed issue amount, you must complete the Health Questions on the next page.]**

[Amount of elected coverage]  
 \$[10,000]

[Accidental death and dismemberment insurance requested]  
 waive  yes (matches the amount selected above)

[Amount of monthly contribution to the cash accumulation account]  
 waive  \$[100.00]

[Child term coverage]  
 Waive  \$[10,000]

[If you applied for child term insurance, please enter the information below. Either you or your spouse may elect child coverage, but not both.]

|                                |                               |              |               |
|--------------------------------|-------------------------------|--------------|---------------|
| Child's name<br>[Sally B. Doe] | Date of birth<br>[01/18/2004] | Child's name | Date of birth |
| Child's name<br>[Joe C. Doe]   | Date of birth<br>[06/01/2006] | Child's name | Date of birth |
| Child's name                   | Date of birth                 | Child's name | Date of birth |

**[Please sign back of form →]**

**HEALTH QUESTIONS [(must be answered for coverage that is not guaranteed)]**

|  |  |
|--|--|
| [Spouse]<br>[Yes] [No]                                       | [Spouse]<br>[Height] [5'6"] [Weight] [130]   |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | (1) During the past three years, have you for any reason consulted a physician(s) or other health care provider(s) or been hospitalized?   |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | (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? |
| <input type="checkbox"/> <input checked="" type="checkbox"/> | (3) Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (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 you answer yes to any question, please provide details below or on a separate sheet of paper.

| [Name] | [Date] | [Name and address of doctor, clinic or hospital] | [Reason for consultation] | [Diagnosis and treatment] |
|--------|--------|--|---------------------------|---------------------------|
|        |        |  |                           |                           |

**CONSUMER PRIVACY NOTICE**

To underwrite your insurance request, the Company may ask for additional personal information, such as an insurance medical exam; lab tests; medical records from your insurance company, physician or hospital; a report from the Medical Information Bureau (MIB), a non-profit organization of life insurance companies that exchanges information among its members. Information about your insurability is confidential. Without your express authorization, the Company or its reinsurers may send your information to government agencies that regulate insurance; or, without identifying you, to insurance organizations for statistical studies; or may make a brief report of health information to the MIB. If you apply to a MIB member company for life or health insurance, or submit a benefits claim for benefits to a member company, the MIB, upon request, will supply the member company with the information in its file. You or your authorized representative have the right to: receive by mail or to copy your personal information in the Company or MIB files, including the source and who received copies within the past two years; to correct or amend personal information in these files; to know specific reasons why coverage was not issued as applied for; and to revoke your authorization at any time. At your written request, within 30 days the Company will explain in writing how to learn what is in your file, its source, how to correct or amend it or how to learn why coverage was not issued as applied for. You can send a written statement as to why you disagree. If we correct or amend the information, we will notify you and anyone who may have received the information. If we do not agree with your statement, we will notify you and keep your statement in your file.

**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  
Telephone: [800-872-2214]

**For information about the MIB, you may contact:**

MIB  
50 Braintree Hill, Suite 400  
Braintree, MA 02184-8734  
MIB Telephone: (866) 692-6901  
MIB TTY: (866) 346-3642  
Website: www.mib.com

**[AUTHORIZATION]**

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. If I do not revoke this authorization, it will be valid for 24 months from the date I sign it. A photocopy shall be as valid as the original. I have read this Authorization and the Consumer Privacy Notice on the second page and I understand that I can have copies.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

|   |  |  |                               |
|---|--|--|-------------------------------|
| [Spouse signature]<br>X [ /s/ Jane A. Doe ] | [Daytime phone number]<br>[(111) 222-3333] | [Evening phone number]<br>[(111) 222-4444] | [Date signed]<br>[03-01-2011] |
|---|--|--|-------------------------------|

**[FOR HOME OFFICE USE ONLY: ]****[POLICY NUMBER: 123456 ]**

| [Spouse]                                     |                                   |                                     | [Children]                                   |                                   |                                     |
|--|-----------------------------------|-------------------------------------|--|-----------------------------------|-------------------------------------|
| [Current in force]<br>[\$ 0.00 ]             | [U/W applied for]<br>[\$ 50,000 ] | [Total elected]<br>[\$ 50,000 ]     | [Current in force]<br>[\$ 0.00 ]             | [U/W applied for]<br>[\$ 10,000 ] | [Total elected]<br>[\$ 10,000 ]     |
| <input checked="" type="checkbox"/> Approved | <input type="checkbox"/> Declined | <input type="checkbox"/> Incomplete | <input checked="" type="checkbox"/> Approved | <input type="checkbox"/> Declined | <input type="checkbox"/> Incomplete |
| [By]<br>[ /s/ Joe Underwriter ]              |                                   |                                     | [Date]<br>[04-01-2011]                       |                                   |                                     |

# Group Universal Life Employee Application

**MINNESOTA LIFE**

Minnesota Life Insurance Company – A Securian Company  
400 Robert Street North • B2-4256 • St. Paul, Minnesota 55101-2098

**[EMPLOYER:] [ABC Company]**

**[POLICY NUMBER:] [12345-G]**

**[INSURED'S INFORMATION (insured is the owner of the insurance unless otherwise requested)]**

|                                       |                                      |   |  |
|---------------------------------------|--------------------------------------|---|--|
| [Employee name]<br>[John C. Doe]      | [Date of birth]<br>[01/10/1975]      | [Social Security number]<br>[123-45-6789] | [Gender]<br><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female |
| [Street address]<br>[456 Main Street] | [City]<br>[Anytown]                  | [State]<br>[USA]                          | [Zip code]<br>[00000]  |
| [Email address]<br>[j.doe@work.com]   |                                      |   |  |
| [Occupation]<br>[computer programmer] | [Date of employment]<br>[01/01/2010] | [Annual salary]<br>[\$100,000]            | [Payroll frequency]<br>[Monthly]   |

Yes  No Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form?

Yes  No On the date you sign this application, are you actively working at your employer's normal place of business at least [20] hours per week?

|   |                                       |   |
|---|---------------------------------------|---|
| [Primary beneficiary designation (include full name and address)]<br>[Jane A. Doe]  | [Relationship]<br>[Spouse]            | [Share % (must total 100%)]<br>[100%]         |
| [Contingent beneficiary designation (include full name and address) <i>Contingent Beneficiaries collect only if all Primary Beneficiaries predecease the insured.</i> ]<br>[Sally B. Doe]<br>[Joe C. Doe] | [Relationship]<br>[Daughter]<br>[Son] | [Share % (must total 100%)]<br>[50%]<br>[50%] |

**[INSURANCE INFORMATION]**

[If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form.]

[Amount of automatic coverage]  
 \$[10,000]

[Amount of elected coverage ]  
 waive  1x  2x  3x  4x  5x  6x  7x  8x  9x  10x annual salary

[Accidental death and dismemberment insurance requested]  
 waive  yes (matches the amount selected above)

[Amount of monthly contribution to the cash accumulation account]  
 waive  \$[100.00]

[Spouse term life rider]  
 waive  \$[50,000]

[Child term coverage]  
 waive  \$[10,000]

[If you applied for spouse or child term insurance, please enter the information below:

|                                |                               |  |                               |
|--------------------------------|-------------------------------|--|-------------------------------|
| Spouse's name<br>[Jane A. Doe] | Date of birth<br>[02/28/1980] | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form? |                               |
| Child's name<br>[Joe C. Doe]   | Date of birth<br>[06/01/2006] | Child's name<br>[Sally B. Doe]   | Date of birth<br>[01/18/2004] |
| Child's name                   | Date of birth                 | Child's name   | Date of birth                 |

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

|   |  |  |                               |
|---|--|--|-------------------------------|
| [Employee signature]<br>X [ /s/ John C. Doe ] | [Daytime phone number]<br>[(111) 222-3333] | [Evening phone number]<br>[(111) 222-4444] | [Date signed]<br>[03-01-2011] |
| [Spouse signature]<br>X [ /s/ Jane A. Doe ]   | [Daytime phone number]<br>[(111) 222-3333] | [Evening phone number]<br>[(111) 222-4444] | [Date signed]<br>[03-01-2011] |

# Group Universal Life Spouse Application

MINNESOTA LIFE

Minnesota Life Insurance Company – A Securian Company  
400 Robert Street North • B2-4256 • St. Paul, Minnesota 55101-2098

**[EMPLOYER:] [ABC Company]**

**[POLICY NUMBER:] [12345-G]**

## EMPLOYEE INFORMATION

|                                       |                                 |   |  |
|---------------------------------------|---------------------------------|---|--|
| [Employee name]<br>[John C. Doe]      | [Date of birth]<br>[01/10/1975] | [Social Security number]<br>[123-45-6789] | [Gender]<br><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female |
| [Street address]<br>[456 Main Street] | [City]<br>[Anytown]             | [State]<br>[USA]                          | [Zip code]<br>[00000]  |

## SPOUSE INFORMATION (spouse is the owner of the insurance unless otherwise requested)

|  |                                 |   |  |
|--|---------------------------------|---|--|
| [Spouse name]<br>[Jane A. Doe]   | [Date of birth]<br>[02/28/1980] | [Social Security number]<br>[912-34-5678] | [Gender]<br><input type="checkbox"/> Male <input checked="" type="checkbox"/> Female |
| [Street address (check here if same as above <input checked="" type="checkbox"/> ) | [City]                          | [State]                                   | [Zip code]   |
| [Email address]<br>[j.doe@work.com]  | [Occupation]<br>[nurse]         |   |  |

Yes  No Have you used tobacco in any form during the past 12 months or are you currently using nicotine in any form?

|   |                                       |   |
|---|---------------------------------------|---|
| [Primary beneficiary designation (include full name and address)]<br>[John C. Doe]  | [Relationship]<br>[Spouse]            | [Share % (must total 100%)]<br>[100%]         |
| [Contingent beneficiary designation (include full name and address) <i>Contingent Beneficiaries collect only if all Primary Beneficiaries predecease the insured.</i> ]<br>[Sally B. Doe]<br>[Joe C. Doe] | [Relationship]<br>[Daughter]<br>[Son] | [Share % (must total 100%)]<br>[50%]<br>[50%] |

## INSURANCE INFORMATION

[If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form.]

|  |
|--|
| [Amount of elected coverage]<br><input checked="" type="checkbox"/> \$[10,000]   |
| [Accidental death and dismemberment insurance requested]<br><input type="checkbox"/> waive <input checked="" type="checkbox"/> yes (matches the amount selected above) |
| [Amount of monthly contribution to the cash accumulation account]<br><input type="checkbox"/> waive <input checked="" type="checkbox"/> \$[100.00]                     |
| [Child term coverage]<br><input type="checkbox"/> Waive <input checked="" type="checkbox"/> \$[10,000]   |

[If you applied for child term insurance, please enter the information below. Either you or your spouse may elect child coverage, but not both.]

|                                |                               |                              |                               |
|--------------------------------|-------------------------------|------------------------------|-------------------------------|
| Child's name<br>[Sally B. Doe] | Date of birth<br>[01/18/2004] | Child's name<br>[Joe C. Doe] | Date of birth<br>[06/01/2006] |
| Child's name                   | Date of birth                 | Child's name                 | Date of birth                 |
| Child's name                   | Date of birth                 | Child's name                 | Date of birth                 |

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

|   |  |  |                               |
|---|--|--|-------------------------------|
| [Spouse signature]<br>X [ /s/ Jane A. Doe ] | [Daytime phone number]<br>[(111) 222-3333] | [Evening phone number]<br>[(111) 222-4444] | [Date signed]<br>[03-01-2011] |
|---|--|--|-------------------------------|

SERFF Tracking Number: MNNL-127117660 State: Arkansas  
Filing Company: Minnesota Life Insurance Company State Tracking Number: 48735  
Company Tracking Number: PJM-492  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Group Universal Life Insurance  
Project Name/Number: GUL 2 (2011 App, Actuarial Memorandum & MVT)/PJM-492

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

Attached is the Certification of Readability.

**Attachment:**

Certification of Readability.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Manual of Variable Text for  
Applications

**Comments:**

Attached are the Manual of Variable Text for the Applications submitted for review.

**Attachments:**

11-31334.3 MVT\_4-27-2011.pdf

11-31335.3 MVT\_3-16-2011.pdf

11-31332.3 MVT\_4-27-2011.pdf

11-31333.3 MVT\_3-16-2011.pdf

## Certification of Readability

This is to certify that the below application(s) have achieved a Flesch Reading Score that complies with requirements of Arkansas, Stat. §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| <u>Application Form #</u> | <u>Flesch Score</u> |
|---------------------------|---------------------|
| 11-31332.3                | 53.5                |
| 11-31333.3                | 52.4                |
| 11-31334.3                | 47.3                |
| 11-31335.3                | 48.3                |



\_\_\_\_\_  
Signature (Must be an Officer)

Name: Paula J. Moris

Title: Assistant Secretary

Date: May 10, 2011

If an insurer chooses to score certain forms as separate from the policy with which they may be used, this information must be contained in the certificate.

If a policy is scored by a method other than the Flesch reading ease score, use of the alternate method shall be explained in detail.

### Manual of Variable Text - Form 11-31334.3

1. "Group Universal Life Employee Application", the form title, may be changed to "ABC Company Group Universal Life Employee Application" or something similar if the policyholder so desires.
2. "Minnesota Life Insurance Company – A Securian Company" and address may be changed to reflect an address change in our administration area or a company name change.
3. "Employer" may be changed to "Company," "Firm" or something similar if the policyholder so desires.
4. "Policy Number" may be removed or changed to include a reference to Units or some other similar policy-related indicator.
5. "Insured's Information (insured is the owner of the insurance unless otherwise requested)" may be changed to "Applicant Information...", "Team Member Information...", "Partner Information..." or something similar if the policyholder so desires.
6. "Employee name" may be changed to "Applicant name," "Team Member name," "Partner name" or something similar if the policyholder so desires.
7. "Date of birth" may be removed or changed to "Birthdate" or something similar if the policyholder so desires.
8. "Social Security number" may be removed or changed to "SS#," "Employee ID number," "Associate ID number" or something similar if the policyholder so desires.
9. "Gender" may be removed or changed to "Sex" or something similar depending on the plan design.
10. "Street address, City, State, Zip Code" may be changed to "Home location," "Internal delivery code" or something similar if the policyholder so desires.
11. "Email address" may be removed if not included in the plan design.
12. "Occupation" may be removed or changed to "Job Title" or something similar depending on the plan design.
13. "Date of employment" may be removed or changed to "Hire date" or something similar depending on the plan design.
14. "Annual salary" may be removed or changed to "Annual earnings," "Monthly salary" or something similar depending on the plan design.
15. "Payroll frequency" may be removed or changed to "Number of paychecks" or something similar depending on the plan design.
16. "Yes No Have you used tobacco..." may be removed or changed depending on the plan design.
17. "Yes No On the date you sign this application..." may be removed or changed depending on the plan design.
18. "Primary beneficiary designation..." may be removed or changed to "Designate primary beneficiary" or something similar depending on the plan design. Note: all beneficiary information may be captured on a separate form if the policyholder so desires.
19. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
20. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.
21. "Contingent beneficiary designation..." may be removed or changed to "Designate contingent beneficiary" or something similar depending on the plan design.
22. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
23. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.

24. "Insurance Information" may be changed to "Insurance Coverage" or something similar if the policyholder so desires.
25. "If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form." may be removed or changed to "If applying for more than \$XX,XXX you must complete an Evidence of Insurability form." or something similar depending on the plan design.
26. "Amount of automatic coverage" and amount shown may be removed or changed to "Amount of insurance provided by your employer" or something similar depending on the plan design.
27. "Amount of elected coverage" may be changed to "Amount of insurance elected" or something similar depending on the plan design.
28. "Waive, 1x - 10x annual salary" may be changed to "Waive, \$X,XXX, \$XX,XXX etc." to match the plan design.
29. "Accidental death and dismemberment insurance requested" may be removed or changed to "AD&D insurance requested" or something similar depending on the plan design.
30. "Waive, yes (matches the amount selected above)" may be removed or changed to match the plan design.
31. "Amount of monthly contribution to the cash accumulation account" may be changed to "Cash accumulation account monthly contribution" or something similar depending on the plan design.
32. "Waive, \$XXX.XX" may be changed to match the plan design.
33. "Spouse term life rider" may be removed or changed to "Spouse/Domestic Partner term life rider coverage..." or something similar depending on the plan design.
34. "Waive, \$XX,XXX" may be removed or changed to match the plan design.
35. "Child term coverage" may be removed or changed to "Dependent term coverage" or something similar depending on the plan design.
36. "Waive, \$XX,XXX" may be removed or changed to match the plan design.
37. "If you applied for spouse or child term insurance, please enter the information below." and "Spouse's name," "date of birth," "[ ] Yes [ ] No Have you used tobacco..." "Child's name" and "date of birth" may be removed or changed to "If you applied for spouse/domestic partner or dependent term insurance..." or something similar depending on the plan design.
38. "Employee signature" may be changed to "Applicant signature," "Team Member signature," "Partner signature" or something similar if the policyholder so desires.
39. "Daytime phone number" may be changed to "Day telephone number" or something similar if the policyholder so desires.
40. "Evening phone number" may be removed or changed to "Night telephone number" or something similar if the policyholder so desires.
41. "Date signed" may be changed to "Today's Date" or something similar if the policyholder so desires.
42. "Spouse signature" may be removed or changed to "Spouse/Domestic Partner signature," "Dependent signature," "Applicant signature" or something similar if the policyholder so desires.
43. "Daytime phone number" may be removed or changed to "Day telephone number" or something similar if the policyholder so desires.
44. "Evening phone number" may be removed or changed to "Night telephone number" or something similar if the policyholder so desires.
45. "Date signed" may be removed or changed to "Today's Date" or something similar if the policyholder so desires.

### Manual of Variable Text - Form 11-31335.3

1. "Group Universal Life Spouse Application", the form title, may be changed to "ABC Company Group Universal Life Spouse Application" or something similar if the policyholder so desires.
2. "Minnesota Life Insurance Company – A Securian Company" and address may be changed to reflect an address change in our administration area or a company name change.
3. "Employer" may be changed to "Company," "Firm" or something similar if the policyholder so desires.
4. "Policy Number" may be removed or changed to include a reference to Units or some other similar policy-related indicator.
5. "Employee Information" may be changed to "Applicant Information," "Team Member Information," "Partner Information" or something similar if the policyholder so desires.
6. "Employee name" may be changed to "Applicant name," "Team Member name," "Partner name" or something similar if the policyholder so desires.
7. "Date of birth" may be removed or changed to "Birthdate" or something similar if the policyholder so desires.
8. "Social Security number" may be removed or changed to "SS#," "Employee ID number" or something similar if the policyholder so desires.
9. "Gender" may be removed or changed to "Sex" or something similar depending on the plan design.
10. "Street address, City, State, Zip Code" may be changed to "Home location," "Internal delivery code, or something similar if the policyholder so desires.
11. "Spouse Information (spouse is the owner of the insurance unless otherwise requested)" may be changed to "Spouse/Domestic Partner Information...," "Dependent Information...," "Applicant Information..." or something similar if the policyholder so desires.
12. "Spouse name" may be changed to "Spouse/Domestic Partner name," "Dependent name," "Applicant name" or something similar if the policyholder so desires.
13. "Date of birth" may be changed to "Birthdate" or something similar if the policyholder so desires.
14. "Social Security number" may be removed or changed to "SS#" or something similar if the policyholder so desires.
15. "Gender" may be removed or changed to "Sex" or something similar depending on the plan design.
16. "Street address (check here if same as above [ ]), City, State, Zip Code" may be changed to "Home location" or something similar if the policyholder so desires.
17. "Email address" may be removed if not included in the plan design.
18. "Occupation" may be removed or changed to "Job Title" or something similar depending on the plan design.
19. "Yes No Have you used tobacco..." may be removed or changed depending on the plan design. In addition we may ask: "On the date you sign this application, are you actively working at least 20 hours per week?" or something similar depending on the plan design.
20. "Primary beneficiary designation..." may be removed or changed to "Designate primary beneficiary" or something similar depending on the plan design. Note: all beneficiary information may be captured on a separate form if the policyholder so desires.
21. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
22. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.

23. "Contingent beneficiary designation..." may be removed or changed to "Designate contingent beneficiary" or something similar depending on the plan design.
24. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
25. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.
26. "Insurance Information" may be changed to "Insurance Coverage" or something similar if the policyholder so desires.
27. "If applying for more than the guaranteed issue amount, you must complete an Evidence of Insurability form." may be removed or changed to "If applying for more than \$XX,XXX you must complete an Evidence of Insurability form." or something similar depending on the plan design.
28. "Amount of elected coverage" and amount shown may be changed to "Amount of insurance elected" or something similar depending on the plan design.
29. "Accidental death and dismemberment insurance requested" may be removed or changed to "AD&D insurance requested" or something similar depending on the plan design.
30. "Waive, yes (matches the amount selected above)" may be removed or changed to match the plan design.
31. "Amount of monthly contribution to the cash accumulation account" may be changed to "Cash accumulation account monthly contribution" or something similar depending on the plan design.
32. "Waive, \$XXX.XX" may be changed to match the plan design.
33. "Child term coverage" may be removed or changed to "Dependent term coverage" or something similar depending on the plan design.
34. "Waive, \$XX,XXX" may be removed or changed to match the plan design.
35. "If you applied for child term insurance, please enter the information below. Either you or your spouse may elect child coverage, but not both." and "Child's name" and "date of birth" may be removed or changed to "If you applied for dependent term insurance..." or something similar depending on the plan design.
36. "Spouse signature" may be removed or changed to "Spouse/Domestic Partner signature," "Dependent signature," "Applicant signature" or something similar if the policyholder so desires.
37. "Daytime phone number" may be removed or changed to "Day telephone number" or something similar if the policyholder so desires.
38. "Evening phone number" may be removed or changed to "Night telephone number" or something similar if the policyholder so desires.
39. "Date signed" may be removed or changed to "Today's Date" or something similar if the policyholder so desires.

### Manual of Variable Text - Form 11-31332.3

1. "Group Universal Life Employee Application", the form title, may be changed to "ABC Company Group Universal Life Employee Application" or something similar if the policyholder so desires.
2. "Minnesota Life Insurance Company – A Securian Company" and address may be changed to reflect an address change in our administration area or a company name change.
3. "Employer" may be changed to "Company," "Firm" or something similar if the policyholder so desires.
4. "Policy Number" may be removed or changed to include a reference to Units or some other similar policy-related indicator.
5. "Insured's Information (insured is the owner of the insurance unless otherwise requested)" may be changed to "Applicant Information...", "Team Member Information...", "Partner Information..." or something similar if the policyholder so desires.
6. "Employee name" may be changed to "Applicant name," "Team Member name," "Partner name" or something similar if the policyholder so desires.
7. "Date of birth" may be removed or changed to "Birthdate" or something similar if the policyholder so desires.
8. "Social Security number" may be removed or changed to "SS#," "Employee ID number," "Associate ID number" or something similar if the policyholder so desires.
9. "Gender" may be removed or changed to "Sex" or something similar depending on the plan design.
10. "Street address, City, State, Zip Code" may be changed to "Home location," "Internal delivery code" or something similar if the policyholder so desires.
11. "Email address" may be removed if not included in the plan design.
12. "Occupation" may be removed or changed to "Job Title" or something similar depending on the plan design.
13. "Date of employment" may be removed or changed to "Hire date" or something similar depending on the plan design.
14. "Annual salary" may be removed or changed to "Annual earnings," "Monthly salary" or something similar depending on the plan design.
15. "Payroll frequency" may be removed or changed to "Number of paychecks" or something similar depending on the plan design.
16. "Yes No Have you used tobacco..." may be removed or changed depending on the plan design.
17. "Yes No On the date you sign this application..." may be removed or changed depending on the plan design.
18. "Primary beneficiary designation..." may be removed or changed to "Designate primary beneficiary" or something similar depending on the plan design. Note: all beneficiary information may be captured on a separate form if the policyholder so desires.
19. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
20. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.
21. "Contingent beneficiary designation..." may be removed or changed to "Designate contingent beneficiary" or something similar depending on the plan design.
22. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
23. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.

24. "Insurance Information" may be changed to "Insurance Coverage" or something similar if the policyholder so desires.
25. "If applying for more than the guaranteed issue amount, you must complete the Health Questions on the next page." may be removed or changed to "If applying for more than \$XX,XXX you must complete the Health Questions on the next page." or something similar depending on the plan design.
26. "Amount of automatic coverage" and amount shown may be removed or changed to "Amount of insurance provided by your employer" or something similar depending on the plan design.
27. "Amount of elected coverage" may be changed to "Amount of insurance elected" or something similar depending on the plan design.
28. "Waive, 1x - 10x annual salary" may be changed to "Waive, \$X,XXX, \$XX,XXX etc." to match the plan design.
29. "Accidental death and dismemberment insurance requested" may be removed or changed to "AD&D insurance requested" or something similar depending on the plan design.
30. "Waive, yes (matches the amount selected above)" may be removed or changed to match the plan design.
31. "Amount of monthly contribution to the cash accumulation account" may be changed to "Cash accumulation account monthly contribution" or something similar depending on the plan design.
32. "Waive, \$XXX.XX" may be changed to match the plan design.
33. "Spouse term life rider" may be removed or changed to "Spouse/Domestic Partner term life rider coverage..." or something similar depending on the plan design.
34. "Waive, \$XX,XXX" may be removed or changed to match the plan design.
35. "Child term coverage" may be removed or changed to "Dependent term coverage" or something similar depending on the plan design.
36. "Waive, \$XX,XXX" may be removed or changed to match the plan design.
37. "If you applied for spouse or child term insurance, please enter the information below." and "Spouse's name," "date of birth," "[ ] Yes [ ] No Have you used tobacco..." "Child's name" and "date of birth" may be removed or changed to "If you applied for spouse/domestic partner or dependent term insurance..." or something similar depending on the plan design.
38. "Please sign back of form" may be removed or changed to "Your signature is required on the back of this form" or something similar depending on the plan design.
39. Under Health Questions "(must be answered for coverage that is not guaranteed)" may be removed or changed to "(must be answered for coverage over \$XX,XXX)" or something similar depending on the plan design.
40. "Employee" and "Spouse" columns of "Yes/No" blocks may be removed or changed depending on the plan design. The word "Employee" could be changed to "Applicant," "Team Member," "Partner" or something similar. The word "Spouse" could be changed to "Spouse/Domestic Partner," "Dependent," "Applicant" or something similar.
41. "Employee Height, Weight" and "Spouse Height, Weight" may be removed or changed depending on the plan design. The word "Employee" could be changed to "Applicant," "Team Member," "Partner" or something similar. The word "Spouse" could be changed to "Spouse/Domestic Partner," "Dependent," "Applicant" or something similar.
42. "Name", "Date", "Name and Address of Doctor, Clinic Hospital", "Reason For Consultation" and "Diagnosis and Treatment" may be changed to "Employee Name," "Applicant Name," "Team Member Name," "Partner Name," "Spouse Name," "Spouse/Domestic Partner Name," "Dependent Name," "Child Name" or something similar.
43. "Authorization" may be changed to "Authorization For Coverage" or something similar if the policyholder so desires.

44. "Employee signature" may be changed to "Applicant signature," "Team Member signature," "Partner signature" or something similar if the policyholder so desires.
45. "Daytime phone number" may be changed to "Day telephone number" or something similar if the policyholder so desires.
46. "Evening phone number" may be removed or changed to "Night telephone number" or something similar if the policyholder so desires.
47. "Date signed" may be changed to "Today's Date" or something similar if the policyholder so desires.
48. "Spouse signature" may be removed or changed to "Spouse/Domestic Partner signature," "Dependent signature," "Applicant signature" or something similar if the policyholder so desires.
49. "Daytime phone number" may be removed or changed to "Day telephone number" or something similar if the policyholder so desires.
50. "Evening phone number" may be removed or changed to "Night telephone number" or something similar if the policyholder so desires.
51. "Date signed" may be removed or changed to "Today's Date" or something similar if the policyholder so desires.
52. "For Home Office Use" may be removed or changed to "For Minnesota Life Use Only" or something depending on the plan design.
53. "Policy Number" may be removed or changed to include a reference to Units or some other similar policy-related indicator.
54. "Employee" may be removed or changed to "Applicant," "Team Member," "Partner" or something similar depending on the plan design.
55. "Spouse" may be removed or changed to "Spouse/Domestic Partner," "Dependent," "Applicant" or something similar depending on the plan design.
56. "Children" may be removed or changed to "Dependent" or something similar depending on the plan design.
57. Columns of "Current in force", "U/W applied for", "Total elected" "Approved", "Declined", "Incomplete", "By" and "Date" blocks may be removed or changed depending on the plan design.

### Manual of Variable Text - Form 11-31333.3

1. "Group Universal Life Spouse Application", the form title, may be changed to "ABC Company Group Universal Life Spouse Application" or something similar if the policyholder so desires.
2. "Minnesota Life Insurance Company – A Securian Company" and address may be changed to reflect an address change in our administration area or a company name change.
3. "Employer" may be changed to "Company," "Firm" or something similar if the policyholder so desires.
4. "Policy Number" may be removed or changed to include a reference to Units or some other similar policy-related indicator.
5. "Employee Information" may be changed to "Applicant Information," "Team Member Information," "Partner Information" or something similar if the policyholder so desires.
6. "Employee name" may be changed to "Applicant name," "Team Member name," "Partner name" or something similar if the policyholder so desires.
7. "Date of birth" may be removed or changed to "Birthdate" or something similar if the policyholder so desires.
8. "Social Security number" may be removed or changed to "SS#," "Employee ID number" or something similar if the policyholder so desires.
9. "Gender" may be removed or changed to "Sex" or something similar depending on the plan design.
10. "Street address, City, State, Zip Code" may be changed to "Home location," "Internal delivery code, or something similar if the policyholder so desires.
11. "Spouse Information (spouse is the owner of the insurance unless otherwise requested)" may be changed to "Spouse/Domestic Partner Information...," "Dependent Information...," "Applicant Information..." or something similar if the policyholder so desires.
12. "Spouse name" may be changed to "Spouse/Domestic Partner name," "Dependent name," "Applicant name" or something similar if the policyholder so desires.
13. "Date of birth" may be changed to "Birthdate" or something similar if the policyholder so desires.
14. "Social Security number" may be removed or changed to "SS#" or something similar if the policyholder so desires.
15. "Gender" may be removed or changed to "Sex" or something similar depending on the plan design.
16. "Street address (check here if same as above [ ]), City, State, Zip Code" may be changed to "Home location" or something similar if the policyholder so desires.
17. "Email address" may be removed if not included in the plan design.
18. "Occupation" may be removed or changed to "Job Title" or something similar depending on the plan design.
19. "Yes No Have you used tobacco..." may be removed or changed depending on the plan design. In addition we may ask: "On the date you sign this application, are you actively working at least 20 hours per week?" or something similar depending on the plan design.
20. "Primary beneficiary designation..." may be removed or changed to "Designate primary beneficiary" or something similar depending on the plan design. Note: all beneficiary information may be captured on a separate form if the policyholder so desires.
21. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
22. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.

23. "Contingent beneficiary designation..." may be removed or changed to "Designate contingent beneficiary" or something similar depending on the plan design.
24. "Relationship" may be removed or changed to "How do you know this person" or something similar depending on the plan design.
25. "Share %" may be removed or changed to "Benefit %" or something similar depending on the plan design.
26. "Insurance Information" may be changed to "Insurance Coverage" or something similar if the policyholder so desires.
27. "If applying for more than the guaranteed issue amount, you must complete the Health Questions on the next page." may be removed or changed to "If applying for more than \$XX,XXX you must complete the Health Questions on the next page." or something similar depending on the plan design.
28. "Amount of elected coverage" and amount shown may be changed to "Amount of insurance elected" or something similar depending on the plan design.
29. "Accidental death and dismemberment insurance requested" may be removed or changed to "AD&D insurance requested" or something similar depending on the plan design.
30. "Waive, yes (matches the amount selected above)" may be removed or changed to match the plan design.
31. "Amount of monthly contribution to the cash accumulation account" may be changed to "Cash accumulation account monthly contribution" or something similar depending on the plan design.
32. "Waive, \$XXX.XX" may be changed to match the plan design.
33. "Child term coverage" may be removed or changed to "Dependent term coverage" or something similar depending on the plan design.
34. "Waive, \$XX,XXX" may be removed or changed to match the plan design.
35. "If you applied for child term insurance, please enter the information below. Either you or your spouse may elect child coverage, but not both." and "Child's name" and "date of birth" may be removed or changed to "If you applied for dependent term insurance..." or something similar depending on the plan design.
36. "Please sign back of form" may be removed or changed to "Your signature is required on the back of this form" or something similar depending on the plan design.
37. Under Health Questions "(must be answered for coverage that is not guaranteed)" may be removed or changed to "(must be answered for coverage over \$XX,XXX)" or something similar depending on the plan design.
38. "Spouse" columns of "Yes/No" blocks may be changed depending on the plan design. The word "Spouse" could be changed to "Spouse/Domestic Partner," "Dependent," "Applicant" or something similar depending on the plan design.
39. "Spouse Height, Weight" may be changed depending on the plan design. The word "Spouse" could be changed to "Spouse/Domestic Partner," "Dependent," "Applicant" or something similar depending on the plan design.
40. "Name", "Date", "Name and Address of Doctor, Clinic Hospital", "Reason For Consultation" and "Diagnosis and Treatment" may be changed to "Spouse Name," "Spouse/Domestic Partner Name," "Dependent Name," "Child Name" or something similar depending on the plan design.
41. "Authorization" may be changed to "Authorization For Coverage" or something similar if the policyholder so desires.
42. "Spouse signature" may be removed or changed to "Spouse/Domestic Partner signature," "Dependent signature," "Applicant signature" or something similar if the policyholder so desires.
43. "Daytime phone number" may be removed or changed to "Day telephone number" or something similar if the policyholder so desires.

44. "Evening phone number" may be removed or changed to "Night telephone number" or something similar if the policyholder so desires.
45. "Date signed" may be removed or changed to "Today's Date" or something similar if the policyholder so desires.
46. "For Home Office Use" may be removed or changed to "For Minnesota Life Use Only" or something depending on the plan design.
47. "Policy Number" may be removed or changed to include a reference to Units or some other similar policy-related indicator.
48. "Spouse" may be removed or changed to "Spouse/Domestic Partner," "Dependent," "Applicant" or something similar depending on the plan design.
49. "Children" may be removed or changed to "Dependent" or something similar depending on the plan design.
50. Columns of "Current in force", "U/W applied for", "Total elected" "Approved", "Declined", "Incomplete", "By" and "Date" blocks may be removed or changed depending on the plan design.