MINNESOTA MEDICAL ASSOCIATION

ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM
(Policy 1588-1)

Member Name _____

Member Address _____

Member City, State, Zip _____

1) Check Coverage Desired: $500,000 Benefit Amount __ Member & Family __Member Only

$250,000 Benefit Amount __ Member & Family __Member Only

2) Please Fill In Information: Date of Birth (mm/dd/year): _____

Social Security Number: _____

3) Automatic Beneficiary Designation

Your beneficiary will be your legal spouse. If you have no spouse, proceeds will be payable in the following order: your children, your parents, your estate. If you wish to make other beneficiary arrangements, please complete below. If space below is not sufficient, please attach a separate page:

Member's beneficiary: _____

Relationship to member: _____

Beneficiary's address: _____

4) Read Carefully, then Sign and Date

I wish to enroll in the Minnesota Medical Association endorsed Group AD&D Insurance Plan underwritten by ReliaStar Life Insurance Company. I have read and understand the conditions and exclusions as described in the enclosed materials. I understand that coverage is effective on the first day of the month after I receive my Certificate of Insurance indicating the effective date of coverage, provided my first premium is paid during the lifetime of the insured. To the best of my knowledge and belief, the information I've provided is complete and correct. I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life and the first premium is paid in my lifetime. I understand my coverage begins on the "effective date" assigned by ReliaStar life.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

X _____ **_____**

Member's Signature **Date Signed**

Return in the enclosed reply envelope to: Member Advantage, 3433 Broadway Street NE, Suite 187, Minneapolis, MN 55413, or email scanned copy to mma@mnmed.org. Questions call 612-378-1875.