

Group Division Claims • P. O. Box 64114 • St. Paul, MN 55164-0114 • FOR CLAIM INFORMATION CALL: Toll Free 1 888 658-0193 Fax 651-665-7106

To present your claim under the Terminal Condition Option of your policy, please fully complete this form. Please note: Recently enacted legislation provides that benefits received under the Terminal Condition Option may not be included in your taxable income. However, benefits received under the Confinement or Hospice Care Option are likely to be included in your taxable income. You should seek assistance from your personal tax advisor to determine the taxability of benefits related to your individual situation. In addition, the receipt of benefits under this rider may adversely affect your eligibility for Medicaid or other government benefits or entitlements. Please fill in your name and date of birth below. Your physician should complete the remainder of the form. Return completed form to Minnesota Life at the above address.

CLAIM NUMBER

PLEASE NOTE, WE ARE REQUESTING YOUR PHYSICIAN SUBMIT COPIES OF YOUR MEDICAL RECORDS WITH THIS FORM TO ASSIST IN OUR REVIEW.

Please PRINT or TYPE answers clearly, and answer all questions as completely as possible. Unanswered questions could result in additional requests for information and require additional time in processing this claim.

1. CLAIMANT'S NAME (Last, First, Middle Initial) 2. CLAIMANT'S DATE OF BIRTH (Mo./Day/Yr)

ATTENDING PHYSICIAN'S STATEMENT - To be completed by the physician currently treating the claimant. All questions must be fully completed. The physician must sign and date this form. Copies of medical records should also be attached.

PATIENT HISTORY

1. HAVE YOU TREATED OR ADVISED THIS PATIENT FOR ANY CONDITION DURING THE PAST FIVE YEARS OTHER THAN CURRENT CONDITION 2. IF YES, GIVE DIAGNOSIS AND DATES OF TREATMENT

3. HAS PATIENT RECEIVED TREATMENT FROM ANOTHER PHYSICIAN 4. NAME OF PHYSICIAN

CURRENT CONDITION

1. PRESENT DIAGNOSIS INCLUDING ANY COMPLICATIONS (Describe Fully) 2. WEIGHT 3. HEIGHT

4. SUBJECTIVE SYMPTOMS

5. OBJECTIVE FINDINGS (including current x-rays, EKG's, laboratory data and any clinical findings)

6. DATE OF FIRST VISIT (Mo./Day/Yr) 7. DATE OF LAST VISIT (Mo./Day/Yr) 8. FREQUENCY

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

ATTENDING PHYSICIAN'S STATEMENT - (Continued)

NATURE OF SERVICE

1. PATIENT'S NAME (Last, First, Middle Initial)		2. DATE OR BIRTH (MO/DAY/YR)	
3. IS THE PATIENT CURRENTLY CONFINED OR RECEIVING HOSPICE CARE	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. IF YES, WHAT TYPE	
		<input type="checkbox"/> Skilled Confinement	<input type="checkbox"/> Intermediate Confinement
		<input type="checkbox"/> Custodial Confinement	<input type="checkbox"/> Hospice Care
		<input type="checkbox"/> Other (Specify)	
5. IF SURGERY PERFORMED - WHAT TYPE - DATE OF SURGERY			
6. LIST MEDICATIONS			

PROGRESS

1. PATIENT HAS ... (Check one)	2. IF RECOVERED, (Mo/Day/Yr) DATE OF RECOVERY
<input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed	
3. DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION	4. PLEASE EXPLAIN
<input type="checkbox"/> Yes-Improved <input type="checkbox"/> Yes-Deterioration <input type="checkbox"/> No	

5. IS THE PATIENT'S CONDITION TERMINAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. IF YES, WHAT IS THE PATIENT'S LIFE EXPECTANCY
7. PLEASE DESCRIBE THE BASIS FOR YOUR LIFE EXPECTANCY ESTIMATE		

8. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS THEREOF	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. REMARKS
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NAME OF ATTENDING PHYSICIAN (Please print)	DEGREE	TELEPHONE ()
PHYSICIAN'S ADDRESS (Street, City, State, Zip)	PRINT NAME OF PERSON COMPLETING THIS FORM	
SIGNATURE OF ATTENDING PHYSICIAN	DATE SIGNED	

X

**Please Attach Medical Records
That Support Patient's
Life Expectancy**

Minnesota Life
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