Notice of Claim for Accelerated Benefit

Minnesota Life Insurance Company - A Securian Company
Claims • PO Box 259708 • Madison, WI 53725-9708

For claim information call:
1-866-295-8690
Fax 608-277-8665

MINNESOTA LIFE

To present your claim under the Accelerated Benefit Option of your policy, please fully complete this form.

Please Note: The receipt of any Accelerated Benefit may be taxable to you. You should seek assistance from your personal tax advisor. The receipt of benefits may also adversely affect your eligibility for Medicaid or other government benefits or entitlements.

Part 1-Should be completed by the employer.

Part 2-Should be completed by the claimant or authorized representative. If guardianship or power of attorney has been executed, please attach certified copies of the official designation.

Part 3-Should be completed by your physician. **PLEASE NOTE, WE ARE REQUESTING THAT COPIES OF YOUR MEDICAL RECORDS BE SUBMITTED WITH THIS FORM BY YOUR PHYSICIAN TO ASSIST IN EXPEDITING 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 your claim.

PART 1 - EMPLOYER'S STATEMENT - To be completed by the authorized representative of the employer. If enrollment applications are maintained in your office, please attach a copy.

1. Employee's name		2. Policy number **32872**
3. Date of hire (mo/day/yr)	4. Effective date of insurance (mo/day/yr)	5. Date employee last actively worked (mo/day/yr). If still actively working check here ☐ and skip to #7.

6. Reason for employment termination on above date

☐ Temporary layoff ☐ Leave of absence ☐ Disability ☐ Retirement ☐ Other, please explain:

7. Date to which premiums paid (mo/day/yr)	8. Employee's amount of insurance **$**
9. Name of employer	10. Telephone number of employer
11. Address of employer (street, city, state, zip)	
12. Print name of authorized representative	13. Title
Signature of authorized representative **X**	Date signed

PART 2 - CLAIMANT'S STATEMENT - To be completed by the claimant or authorized representative. All questions must be fully completed. Please be sure to sign and date the authorization.

1. Legal name of claimant	2. Date of birth (mo/day/yr)	3. Policy number

4. Address (street, city, state, zip) ☐ New address?

5. Social Security number	6. Home telephone number	7. Business telephone number

8. Please describe fully the nature of the disease or injury for which you are claiming benefits

9. Date you were first treated for your present condition (mo/day/yr)	10. Were you confined to a hospital? ☐ Yes ☐ No **IF YES, PLEASE PROVIDE INFORMATION BELOW.**		
11. NAME OF HOSPITAL	ADDRESS OF HOSPITAL	DATE ADMITTED (mo/day/yr)	DATE DISCHARGED (mo/day/yr)
a.			
b.			

12. Name and address of physician(s) who treated you for your current condition	DATE FROM	DATE TO
a.		
b.		
c.		

13. Name and address of physician(s) who treated you within the last 5 years for any cause (If none, please check box ☐).	DATES	CAUSE
a.		
b.		
c.		

14. Are you required by law to use this option of your policy to meet claims of creditors? ☐ Yes ☐ No	15. If yes, please explain.
16. Have you filed or do you plan to file for bankruptcy? ☐ Yes ☐ No	17. If yes, please explain.
18. Are you required by a government agency to use this option of your policy in order to apply for, obtain or keep a government benefit or entitlement? ☐ Yes ☐ No	19. If yes, please explain.

20. If your claim for accelerated benefits is approved, please indicate the percentage or amount you wish to receive

For the purpose of determining my eligibility for insurance coverage and benefits, I **authorize** any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS, or AIDS-related conditions.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

This authorization shall be valid for 24 months from the date it is signed. I have read it and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time except to the extent that Minnesota Life has taken action in reliance upon the authorization prior to notice of revocation. Revocation of this authorization by me in writing shall be effective upon receipt by Minnesota Life.

For your protection, state laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. 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.

Signature of insured	Date signed
X	

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PART 3 - ATTENDING PHYSICIAN'S STATEMENT-To be completed by the physician currently treating you. All questions must be fully completed. Please be sure to sign and date this form. Copies of medical records should also be attached.

Name of patient	Physician's reference/patient number

PATIENT HISTORY

1. Have you treated or advised this patient for any condition during the past 5 years other than current condition?

☐ Yes ☐ No

2. If yes, give diagnosis and dates of treatment (mo/day/yr).

3. Has patient received treatment from another physician? (This would be for time before current condition.)

☐ Yes ☐ No

4. Name and address of physician

CURRENT CONDITION

1. Present diagnosis including any complications (describe fully)	Weight	Height

2. Subjective symptoms

3. Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)

4. Date of first visit (mo/day/yr)	5. Date of last visit (mo/day/yr)

6. Frequency

☐ Weekly ☐ Monthly ☐ Other (please specify):

NATURE OF SERVICE

1. Level of care patient requires or you have authorized

☐ Skilled confinement ☐ Intermediate confinement ☐ Custodial confinement

☐ Hospice care ☐ Other (please specify):

2. Give date patient required confinement or hospice care (mo/day/yr)	3. Is confinement or hospice care still required?
From To	☐ Yes ☐ No If no, as of what date (mo/day/yr)?

4. Is confinement or hospice care expected to continue until death?

☐ Yes ☐ No If no, how long do you anticipate the confinement or hospice care will be needed?

5. If surgery performed - what type - date of surgery (mo/day/yr)

6. List medications

ATTENDING PHYSICIAN'S STATEMENT Continued on Next Page

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PART 3 - ATTENDING PHYSICIAN'S STATEMENT - (CONTINUED)

PROGRESS

1. Patient has...(check one)
☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

2. If recovered, date of recovery (mo/day/yr)

3. Do you expect a fundamental or marked change in the patient's condition?
☐ Yes-Improvement ☐ Yes-Deterioration ☐ No

4. Is the patient's condition terminal?
☐ Yes ☐ No

5. If yes, what is the patient's life expectancy?

6. Please describe the basis for your life expectancy estimate

7. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?
☐ Yes ☐ No

8. Remarks

Print name of attending physician	Degree	Telephone number
Physician's address (street, city, state, zip)	Print name of person completing this form	
Signature of attending physician **X**		Date signed

Please Attach Medical Records

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