Claim for Extended Life Insurance Benefits

Minnesota Life Insurance Company - A Securian Company
600 Congress Avenue • Suite 2160 • Austin, TX 78701

For claim information:
1-877-494-1716
Fax 512-236-0199

MINNESOTA LIFE

Please return this completed form to Minnesota Life at the above address.

PART 1 - EMPLOYER'S STATEMENT - To be completed by the authorized representative of the employer.

Policyholder's name	Policy number
Employee's Retirement System of Texas	**34023/34038**

Insured employee's name (last, first, middle initial)	Gender
	☐ Male ☐ Female

Street address (street, city, state, zip)

Date of birth (mo/day/yr)	Date employed (mo/day/yr)	Last 4 digits of SSN

Job title	Date last worked	Salary
		$ Per ☐ Hour ☐ Week ☐ Month ☐ Year

Status on employment date
☐ Full time ☐ Part time If part-time, average hours per week. _____

AGENCY CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

Name of agency	Agency's telephone number

Agency's address (street, city, state, zip)

Name of authorized representative	Email address	Telephone number

Authorized signature	Date
X	

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.

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PART 2 - CLAIMANT'S STATEMENT - To present your claim for benefits, complete the Claimant's Statement. All questions must be fully completed. (To be completed by the employee.)

PLEASE BE SURE TO SIGN AND DATE THE AUTHORIZATION ON THE REVERSE SIDE.

1. Claimant's legal name (last, first, middle initial)	2. Telephone number

3. Permanent address (street, city, state, zip)

4. Height	5. Weight	6. Date of birth (mo/day/yr)	7. Gender ☐ Male ☐ Female

8. Group policy number and group policyholder name
34023/34038 Employee's Retirement System of Texas

9. What was your occupation prior to your disability?	10. Date of employment

11. Employer's name	12. Supervisor's name

13. Employer's address (street, city, state, zip)	14. Telephone number

15. Describe fully the duties you performed in that occupation

16. What was your annual income from your occupation prior to your disability? $	17. What is it now? $	18. Social Security number

19. Circle the number of years you have completed in
Grade school 1 2 3 4 5 6 7 8 High school 9 10 11 12 GED College 1 2 3 4 Vocational training 1 2 3

20. What degrees do you hold?

21. Are you receiving Social Security, Civil Service, Armed Forces or any other disability benefit?
☐ Yes ☐ No If so, from what source

22. What special skills or training do you have?

23. Past occupation job titles (list all prior jobs) If none, please check box ☐	Starting employment dates	Ending employment dates	Job duties

24. On what date did your injury occur or disability commence?	25. On what date did you last actively perform the duties of your job?

26. Are you now totally disabled and unable to perform your job? ☐ Yes ☐ No	27. Will your disability be permanent? ☐ Yes ☐ No
28. If no, when will you resume all or part of your work?	29. If part, what duties?

30. Describe fully the nature of the disease or injury causing your disability

31. Are you currently enrolled in a vocational rehabilitation program? ☐ Yes ☐ No	32. If yes, list counselor's name, address and telephone number

33. If you are not currently enrolled, do you plan to attend a rehabilitation program in the future?
☐ Yes ☐ No

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34. When did you first consult a physician for your disability?

35. List physicians who have treated you for your disability

Name (last, first, middle initial)	Address (street, city, state, zip)	Telephone number
Diagnosis		Date (mo/day/yr)
Name (last, first, middle initial)	Address (street, city, state, zip)	Telephone number
Diagnosis		Date (mo/day/yr)
Name (last, first, middle initial)	Address (street, city, state, zip)	Telephone number
Diagnosis		Date (mo/day/yr)

36. Dates of hospitalizations

From / To /	Hospital name	
Hospital address		Telephone number
From / To /	Hospital name	
Hospital address		Telephone number

37. Describe fully any work you are now doing or your current daily activities and any remarks

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 the **Employees Retirement System of Texas** (ERS) or their authorized representatives. 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 or ERS 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 the Company or ERS have taken action in reliance upon it.

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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. Copies of medical records should also be attached.

- ☐ Please have this form completed immediately.
- ☐ Please have this form completed on or after _____ .
- ☐ Please have this form completed on _____ or upon recovery if sooner.
- ☐ If you remain disabled beyond _____ and wish further consideration of your claim, please have this completed on _____ or upon recovery if sooner.

The insured is responsible for the completion of this form without expense to the Company. Both sides of this form must be fully completed by the attending physician.

Patient's name (last, first, middle initial)			Telephone number
Date of birth (mo/day/yr)	Height	Weight	Blood pressure reading/date

HISTORY

1. Date symptoms first appeared or accident occurred (mo/day/yr)	2. Date patient ceased work due to disability (mo/day/yr)	3. Is condition due to injury or illness arising out of patient's employment? If yes, check one ☐ Yes ☐ No ☐ Injury ☐ Illness

4. Has patient ever had same or similar condition? If yes, state when and describe.
☐ Yes ☐ No

5. Names and addresses of other treating physicians

DIAGNOSIS

1. Diagnosis including any complications for current condition	2. Patient account/file number

3. Subjective symptoms

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

NATURE AND DATES OF SERVICE

1. Date of first visit (mo/day/yr)	2. Date of last visit (mo/day/yr)	3. Date of next visit (mo/day/yr)	4. Frequency

5. Has patient been hospitalized? If yes, give dates.
☐ Yes ☐ No From _____ through _____

6. Was surgery performed? If yes, state when and describe.
☐ Yes ☐ No

7. Name and address of hospital

8. Is the patient currently enrolled in any type of rehabilitation program?
☐ Yes ☐ No

9. If yes, what type of program?
☐ Cardiac ☐ Physical therapy ☐ Other _____

10. List medications

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CARDIAC Functional capacity (American Heart Association)

☐ CLASS 1 (No limitation) ☐ CLASS 2 (Slight limitation) ☐ CLASS 3 (Marked limitation) ☐ CLASS 4 (Complete limitation)

1. Describe the basis for above classification

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work. *No restrictions (0 - 10%).
☐ Class 2 – Medium manual activity* (15 - 30%).
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35 - 55%).
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administration (sedentary*) activity (60 - 70%).
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75 - 100%).

1. List all restrictions and describe the basis for above classification

MENTAL/NERVOUS IMPAIRMENT

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation).
☐ Class 5 – Patient has significant loss of psychological, personal and social adjustment (severe limitations).

1. Describe the basis for above classification

2. Do you feel this patient is competent to endorse and direct the use of proceeds thereof?

☐ Yes ☐ No

PROGRESS

1. Patient has . . . (check all that apply) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed ☐ Reached maximum medical improvement - impairment rating of _____ %

2. If recovered, date released to return to work (mo/day/yr)

3. Patient is . . . (check one) ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

4. Patient is a suitable candidate for ☐ Trial employment ☐ Full-time ☐ Part-time ☐ Work hardening ☐ Job retraining

PROGNOSIS	REGULAR WORK	OTHER WORK
1. Is patient now totally disabled?	☐ Yes ☐ No If no, date released _____	☐ Yes ☐ No If no, date released _____
2. Do you expect a change in the future relating to patient's ability to work?	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No
a) If improvement is expected, when will patient recover sufficiently to perform duties?	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____
b) If no, please explain.		

Remarks

Have you provided information for this patient for another insurance company or agency?

☐ Yes ☐ No If yes, list company/agency name, telephone number and claim number.

Name of attending physician (please print)	Degree	Telephone number

Physician's address (street, city, state, zip)

Signature of attending physician	Date signed	Print name of person completing this form
X		

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