

Accelerated Life Insurance Benefit Claim

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



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

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

Please Note: The receipt of any Accelerated Life 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. If retired, no need to complete.

1. Employee's name		2. Policy number 34023/34038	
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 <input type="checkbox"/> and skip to #7.	
6. Reason for employment termination on above date <input type="checkbox"/> Temporary layoff <input type="checkbox"/> Leave of absence <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other, please explain			
7. Date to which premiums paid (mo/day/yr)			
8. Salary on date last worked \$		9. Effective date of that salary (mo/day/yr)	
Please complete items #10, 11, and 12 only if claim is for a dependent; otherwise skip to item #13. (If retired, no need to complete #13-17)	10. Name of insured dependent		11. Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child
	12. Effective date of dependent's coverage (mo/day/yr)		
13. Name of agency		14. Telephone number of agency	
15. Address of agency (street, city, state, zip)			
16. Print name of authorized representative		17. Title	
Signature of authorized representative X		Date signed	



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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 34023/34038
4. Address (street, city, state, zip) <input type="checkbox"/> New address?			
5. Last 4 digits of 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>).		DATES	CAUSE
a.			
b.			
c.			
14. Are you required by law to use this option of your policy to meet claims of creditors? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. If yes, please explain.		
16. Have you filed or do you plan to file for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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. Revocation of this authorization by me in writing shall be effective upon receipt by Minnesota Life or ERS.

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 X	Date signed
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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
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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)
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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) From _____ To _____	3. Is confinement or hospice care still required? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, as of what date (mo/day/yr)?
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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) <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed	2. If recovered, date of recovery (mo/day/yr)
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. If yes, what is the patient's life expectancy?
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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	Date signed	

X

Please Attach Medical Records

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