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

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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
Employees Retirement System of Texas	**34023/34038**

Insured employee's name	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	

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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	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 Employees 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. Have you applied for or are you receiving Social Security, Civil Service, Armed Forces, unemployment or any other disability benefits?

☐ 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. Are you now totally disabled and unable to perform any occupation which you were previously able to perform based on your training, education and experience?

☐ Yes ☐ No

28. Will your disability be permanent? ☐ Yes ☐ No	29. If no, when will you resume all or part of your work?

30. If you will resume only part of your work, what duties will you perform?

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

32. Are you currently enrolled in a vocational rehabilitation program? ☐ Yes ☐ No	33. If yes, list counselor's name, address and telephone number.

34. If you are not currently enrolled, do you plan to attend a rehabilitation program in the future?

☐ Yes ☐ No

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

36. List physicians who have treated you for your disability

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

37. Dates of hospitalizations

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

38. Describe fully your ability to perform any work and identify any work you are now doing or have done since you became disabled:

39. Describe fully your current daily activities:

AGREEMENTS AND AUTHORIZATION: I authorize my employer to disclose all information necessary to process my claim to Minnesota Life Insurance Company (Company).

I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's claim department or its authorized representative(s) information about my medical history or treatment and/or to furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize the Company to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

This authorization shall expire on the date that I receive notice of the Company's final decision on my claim. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original.

I, as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from the Company.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, the Company has the right to deny my claim.

For your protection: 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.

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 the claimant remains disabled beyond _____ and wishes further consideration of his/her 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			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, nerve conduction studies, 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. List all restrictions and 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. List all restrictions and describe the basis for above classification

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	ANY 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 likely 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/specialty	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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