Notice of Disability

FC 22

Minnesota Life Insurance Company - A Securian Company
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

MINNESOTA LIFE

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.

CLAIM NUMBER

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
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

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

CLAIM NUMBER

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 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 Minnesota Life.

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 may be 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.

Signature of insured	Date signed
X	

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