Notice of Disability - Claimant Statement

Securian Financial Group, Inc.
Minnesota Life Insurance Company
Austin Branch Office • P.O. Box 64114, St. Paul, MN 55164-0114
1-877-443-5854 • Fax 1-877-494-8401

CLAIM NUMBER

Return fully completed form by mail, fax or upload through our secure internet portal at Securian.com/benefits.

Please **type** or **print** answers clearly and answer all questions as completely as possible. Unanswered questions may result in additional time in processing your claim.

Claim Checklist:

- ☐ Is the Claimant Statement fully completed by the claimant or their authorized representative? If guardianship or power of attorney has been executed, please attach a copy of the certified designation.
- ☐ Has the authorization been signed and dated by the claimant or their authorized representative?
- ☐ Has the Attending Physician Statement been fully completed and signed by your Attending Physician?

Claimant Information

Claimant's legal name (first, middle, last)	Date of birth (mo/day/yr)

Address (street, city, state, zip)

Height	Weight	Telephone number	Gender
			☐ Male ☐ Female

Employment Information

What was your occupation prior to your disability?	Date of employment (mo/day/yr)

Employer's name	Supervisor's name

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

Describe fully the duties you performed in that occupation

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

Employment History

Past occupation job titles (List all prior jobs, if none check this box ☐).	Starting employment date (mo/day/yr)	Ending employment date (mo/day/yr)	Job duties

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

****See Reverse Side****

Education and Training

Circle the number of years you have completed in each of the following:

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

List any degrees you hold and identify the area of study

If applicable, list any additional training classes you have taken and completed and any active/current certifications or occupational licenses you hold.

Benefits

Are you receiving Social Security, Civil Service, Armed Forces, or any other disability benefit?

☐ Yes ☐ No If yes, from what source?

Disability

On what date did your injury occur or disability commence? (mo/day/yr)	On what date did you last actively perform the duties of your job? (mo/day/yr)
Are you now totally disabled and unable to perform your job? ☐ Yes ☐ No	Will your disability be permanent? ☐ Yes ☐ No

If your disability is not permanent, when will you resume all or part of your work? (mo/day/yr)

If part, what duties?

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

Treatment for Your Disability

When did you first consult a physician for your disability? (mo/day/yr)

List physicians who have treated you for your disability

Name of physician		**Reason/Diagnosis**	**Dates**
Address (street, city, state, zip)			
Telephone number	Fax number		
Name of physician		**Reason/Diagnosis**	**Dates**
Address (street, city, state, zip)			
Telephone number	Fax number		
Name of physician		**Reason/Diagnosis**	**Dates**
Address (street, city, state, zip)			
Telephone number	Fax number		

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Provide dates of hospitalization

Hospital name	Dates
Hospital address (street, city, state, zip)	Telephone number
Hospital name	Dates
Hospital address (street, city, state, zip)	Telephone number

Are you currently enrolled in a vocational rehabilitation program?

☐ Yes ☐ No If yes, list counselors name, address and telephone number.

Name of vocational rehabilitation counselor	Telephone number	Fax number
Counselor address (street, city, state, zip)	Estimated completion date (mo/day/yr)	

Describe fully any work you are now doing or your current daily activities

Comments

Authorization for Release of Health-Related Information to Minnesota Life Insurance Company

This Authorization Complies with the HIPAA Privacy Rule.

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 medical or 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 the Company 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 the Company.

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.

SIGN HERE >	**Signature of claimant** X	Date signed (mo/day/yr)

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