Notice of Accidental Loss - Attending Physician 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

This form needs to be completed because this patient has submitted a claim regarding an accidental loss. This form should be completed by the physician most knowledgeable about the loss.

The claimant is responsible for the completion of this form without expense to the Company.

Patient's name (first, middle, last)		Patient's date of birth (mo/day/yr)
Date accident occurred (mo/day/yr)	Date of loss (mo/day/yr)	Date you first treated the patient (mo/day/yr)

Please fully describe the accident and loss

Has the patient ever had the same or similar condition or prior disabilities?
☐ Yes ☐ No

Did the patient have or were they being treated for any illness or disease which caused or contributed to the accident or loss?
☐ Yes ☐ No If yes, please describe.

Dismemberment - complete only if accidental dismemberment occurred

Was there an amputation resulting in severance through or above the wrist or ankle joint?
☐ Yes ☐ No If yes, give complete description of dismemberment.

Paralysis - complete only if accidental paralysis occurred

Please describe the extent of paralysis (For example: monoplegia, hemiplegia, paraplegia, quadriplegia, etc.)

Loss of Sight - complete only if accidental loss of sight occurred

Is the loss of sight in patient's right eye, left eye or both?
☐ Right eye ☐ Left eye ☐ Both

What is the patient's current visual acuity?

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****

Has the patient's visual acuity improved over the past six months?

☐ Yes ☐ No

What is the current treatment plan?

Loss of Hearing - complete only if accidental loss of hearing occurred

Is the loss of hearing in the patient's right ear, left ear or both?

☐ Right ear ☐ Left ear ☐ Both

Have you recommended an evaluation for a cochlear implant?

☐ Yes ☐ No

If so, results of the evaluation?

What is the current treatment plan?

Name of otolaryngologist	Telephone number of otolaryngologist

Address of otolaryngologist (street, city, state, zip)

Prognosis

Other than dismemberment, is the loss entire and irrecoverable?

☐ Yes ☐ No If no, please describe.

Remarks

Signature of Attending Physician

Name of attending physician (please print)	Degree

Physician's address (street)	Telephone number
City, state, zip	Fax number

Name of person completing this form (please print)

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 attending physician X	Date signed (mo/day/yr)

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