# Waiver of Premium Claim
# Employer's Statement

Clear Form

**Minnesota Life Insurance Company,** a Securian Financial Group affiliate
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

| Policyholder's name | Policy number | Branch location/unit number |
|---|---|---|
| The Texas A&M University System | **33769 / 33777** | |

| Insured employee's name (last, first, middle name) | Gender |
|---|---|
| | ☐ Male ☐ Female |

Street address

| Date of birth (mo/day/yr) | Date employed (mo/day/yr) | Social Security number |
|---|---|---|
| | | |

| Job title | Date lasted worked | Salary |
|---|---|---|
| | | $ Per ☐ Hour ☐ Week ☐ Month |

Status on employment date
☐ Full-time ☐ Part-time If part-time, average hours per week. _____ ☐ Retired Date of retirement _____

| | Amount of Employee's Insurance | Effective Date of Coverage |
|---|---|---|
| Basic | $ _____ | _____ |
| Optional | $ _____ | _____ |
| Spouse | $ _____ | _____ |
| Child | $ _____ | _____ |
| Other | $ _____ | _____ |

**EMPLOYER CERTIFICATION:** The undersigned certifies that above statements are correct as reported on its records.

Name of employer

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

| Name of authorized representative | Telephone number | Email address |
|---|---|---|
| | | |

| Signature of authorized representative | Date signed |
|---|---|
| **X** | |