

# Notice of Disability

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Minnesota Life Insurance Company - A Securian Company  
Claims • P.O. Box 64114 • St. Paul, MN 55164-0114

For claim information call:  
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.)

**CLAIM NUMBER**

**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 <input type="checkbox"/> Male <input type="checkbox"/> 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?					
<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>		Starting employment dates		Ending employment dates	
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?			27. Will your disability be permanent?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> 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?		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?	
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> 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	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)

**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 authorization prior to notice of revocation. Revocation of this authorization by me in writing shall be effective upon receipt by Minnesota Life.

**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.

Signature of insured

**X**

Date signed

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