Claimant and Physician Statement

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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 1-800-328-9442
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MINNESOTA LIFE

TO PRESENT YOUR CLAIM FOR BENEFITS, YOU MUST COMPLETE THIS FORM. IF ALL QUESTIONS ARE NOT FULLY ANSWERED THE FORM MAY BE RETURNED FOR COMPLETION. PLEASE BE SURE THAT YOUR STATEMENT AND YOUR PHYSICIAN'S STATEMENT ARE DATED AND SIGNED. THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

CLAIM NUMBER

PART 1 - CLAIMANT'S STATEMENT *To present your claim for benefits, complete this Claimant's Statement. All questions must be fully completed.* **Please sign and date the authorization below.**

1. Legal name of claimant (last, first, middle initial)	2. Social Security number	3. ☐ Male ☐ Female	4. Date of birth (mo/day/yr)

5. Home address (street, city, state, zip)	6. Home telephone number
	( )

7. Name of lending institution	8. Account/loan number	9. Job title at time of disability	10. Hours worked each week

11. Self employed ☐ Yes ☐ No	Name and address of business	Date business began (mo/day/yr)	Business license number

12. Describe your job duties	13. Date of hire (mo/day/yr)

14. Employer's name	15. Employer's address (street, city, state, zip)	16. Employer's telephone number ( )	Ext.

17. Is your disability the result of illness? ☐ Yes ☐ No	18. Date illness began? (mo/day/yr)	19. Date first treated for current illness (mo/day/yr)

20. Is your disability the result of an accidental injury? ☐ Yes ☐ No	21. Date of accident/injury (mo/day/yr)	22. Date first treated for injury (mo/day/yr)	23. Cause of accident/injury ☐ Motor vehicle accident ☐ Work related injury ☐ Other

24. Describe your illness or injury

25. Date you stopped work due to disability (mo/day/yr)	26. Have you missed work for this condition in the past? ☐ Yes ☐ No	27. If yes, give dates you missed work. From To

28. Have you returned to work? ☐ Yes ☐ No	Date returned (mo/day/yr)	Number of hours you are working each week	29. Did you return to work with restrictions? ☐ Yes If yes, describe. ☐ No

30. What physician(s) treated you for your **current disability?**

	Name	Address	Telephone number	Dates
a.				
b.				

31. Who is your family physician? (If none, please check box ☐.)

	Name	Address	Telephone number	Dates	Reason
a.					

32. What physician(s) treated you within **the last 5 years** for any cause? (If none, please check box ☐.) (Attach an additional sheet of paper if necessary.)

	Name	Address	Telephone number	Dates	Reason
a.					
b.					
c.					

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.

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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PART 2 – ATTENDING PHYSICIAN'S STATEMENT *Must be **fully** completed before benefits can be considered.*

1. Patient's name (last, first, middle initial)

2. Date of birth (mo/day/yr)

3. Describe fully, diagnosis and concurrent conditions for current disability (if multiple diagnoses, indicate which diagnoses are disabling in and of themselves)

4. Patient's account or file number

5. Date condition or symptom first appeared

6. Date you were first consulted for this condition

7. Next scheduled appointment

8. List all dates of treatment for this condition

9. Dates of hospitalization
From To

10. Was surgery performed? ☐ Yes ☐ No
Date Type of surgery

11. Was patient referred to you by another physician? ☐ Yes ☐ No

12. Name of referring physician, address, and telephone number

13. Dates patient was unable to work due to disability
From To

14. Date patient able to return to work (or estimate date)

15. If still disabled, when will patient recover sufficiently to perform duties of his/her regular work?
☐ 1 Mo ☐ 2-3 Mo ☐ 4-6 Mo ☐ Never ☐ Other

16. Has patient been treated for this condition within the past two years? ☐ Yes ☐ No

17. By whom? Name of physician, address, and telephone number

18. Have you treated/advised this patient for **any** condition during the past five years? ☐ Yes ☐ No

19. If yes, please give diagnosis and dates of treatment.

20. Is patient still under your care? ☐ Yes ☐ No

21. Name, address, and telephone number of physician, you have referred patient to

22. Date referred

Remarks

Print or type attending physician's name and complete address

Print name of person completing this form

Telephone number ( )

Fax number ( )

Physician's signature
X

Degree

Date signed

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