

Claim for Dismemberment Benefits - Claimant Statement



Securian Financial Group, Inc.
Minnesota Life Insurance Company
PO Box 64114, St. Paul, MN 55164-0114
1-877-494-1716 • 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.
To file your claim for your accidental loss, complete this Claimant Statement. All questions must be fully completed. Have your employer complete the Employer Statement and your physician complete the Attending Physician Statement and attach copies of your medical records. Please be sure to sign and date the authorization.

Claim Checklist

- Is the Claimant Statement fully completed?
- Has your employer completed the Employer Statement?
- Has the authorization been signed and dated by the claimant or their authorized representative?
- Are copies of the medical records attached?

Claimant Information	
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Claimant's legal name (first, middle, last)	Date of birth (mm/dd/yyyy)
Last 4 digits of Social Security number	Telephone number

Address (street, city, state, zip)

Describe the loss you are claiming (for example: loss of sight, loss of hand, etc.)

Describe the accident that caused your loss

Date accident occurred (mm/dd/yyyy)	Where did the accident occur?
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Did the loss occur on the same date as the accident?
 Yes No If no, please provide the date the loss occurred (mm/dd/yyyy):

Was a police or other incident report filed?
 Yes No If yes, please provide a complete copy of the final report.

Is your loss entire and irrecoverable?
 Yes No

Treatment History		Dates (mm/dd/yyyy)
Please list the names and addresses of all physicians or facilities that treated you from the date of your accident to the current date. If more than three physicians or facilities, please attach a separate sheet.		
Name of physician/facility		
Street address		
City, state, zip	Telephone number	
Name of physician/facility		
Street address		
City, state, zip	Telephone number	
Name of physician/facility		
Street address		
City, state, zip	Telephone number	

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 appropriate regulatory body.

SIGN HERE >	Signature of claimant	Date signed (mm/dd/yyyy)
	X	

This claimant statement should be completed by the claimant or authorized representative. If guardianship or power of attorney has been executed, please attach a copy of the certified official designation.

Payment Information - If your benefit is approved, please select your preferred payment method.

CERTIFICATION INSTRUCTIONS: You must cross out item (2) below if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return.

CERTIFICATION - Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Social Security number or Taxpayer Identification number, and
- (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, and
- (3) I am a U.S. person (including a U.S. resident alien).

Certification Notice:

The IRS requires us to obtain certification of your Social Security number or Taxpayer Identification number. Without this information, you may be subject to government imposed backup withholding for any interest paid on this benefit.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Claimant Social Security number							
		+		+			

- Check - I'd like a paper check sent via U.S. mail.
- Direct Deposit - If you select this option, you must complete the Authorization for Direct Deposit section below:

Authorization for Direct Deposit

By electing this option and providing the account information below, I authorize Minnesota Life Insurance Company ("Company") to initiate deposits (credit entries) and corrections (debit entries) to adjust any deposits made in error to my account indicated below.

I authorize the financial institution ("Depository"), named on the attached voided check/deposit slip, to accept these deposits and/or corrections made to this account.

This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on it or until such time as Company terminates this method of payment.

Benefits will not be deposited directly but will be sent to you via a check in any of the following situations:
 a) authorization for Direct Deposit not completed; b) a voided check or deposit slip is not provided; c) we are unable to process the direct deposit.

Account type	Bank routing/transit number	Account number
<input type="checkbox"/> Savings (attach deposit slip) <input type="checkbox"/> Checking (attach voided check)		

By signing below, I attest that the information provided is true and accurate to the best of my knowledge and belief, and I request that the Company proceed with payment of the claim pursuant to the information above.

SIGN HERE >	Signature of claimant X	Date signed (mm/dd/yyyy)
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