

# Notice of Claim for Accelerated Benefit

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**

**Return to State of Tennessee at:** Dept. of Finance and Administration  
 Benefits Administration  
 Suite 1900 WRS TN Tower  
 312 Rosa L. Parks Avenue  
 Nashville, TN 37243

To present your claim under the Accelerated Benefit Option of your policy, please fully complete this form.

**Please Note:** The receipt of any Accelerated Benefit may be taxable to you. You should seek assistance from your personal tax advisor. The receipt of benefits may also adversely affect your eligibility for Medicaid or other government benefits or entitlements.

**Part 1**-Should be completed by the employer.

**Part 2**-Should be completed by the claimant or authorized representative. If guardianship or power of attorney has been executed, please attach certified copies of the official designation.

**Part 3**-Should be completed by your physician. **PLEASE NOTE, WE ARE REQUESTING THAT COPIES OF YOUR MEDICAL RECORDS BE SUBMITTED WITH THIS FORM BY YOUR PHYSICIAN TO ASSIST IN EXPEDITING OUR REVIEW.**

Please **PRINT** or **TYPE** answers clearly, and answer all questions as completely as possible. Unanswered questions could result in additional requests for information and require additional time in processing your claim.

**PART 1 - EMPLOYER'S STATEMENT - To be completed by the authorized representative of the employer. Please attach a copy of the original enrollment form and/or screen shots showing the coverage history, as well as payroll records verifying the employee's annual earnings at the time of death.**

1. Employee's name (last, first, middle initial)		2. Policy number <b>34294</b>
3. Date of hire (mo/day/yr)	4. Employee ID	5. Effective date of insurance (mo/day/yr)
6. Date employee last actively worked (mo/day/yr). If still actively working check here <input type="checkbox"/> and skip to #8.		
7. Reason for employment termination on above date <input type="checkbox"/> Temporary layoff <input type="checkbox"/> Leave of absence <input type="checkbox"/> Disability <input type="checkbox"/> Retirement <input type="checkbox"/> Other, please explain		
8. Date to which premiums paid (mo/day/yr)	9. Employee's amount of insurance (if based on salary, please complete questions 10 & 11) \$	
10. Salary on date last worked \$	11. Effective date of that salary (mo/day/yr)	
<i>Please complete items #12, 13, and 14 only if claim is for a dependent; otherwise skip to item #15.</i>	12. Name of insured dependent (last, first, middle initial)	Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child
	13. Dependent's amount of insurance \$	14. Effective date of dependent's coverage (mo/day/yr)
15. Name of employer <b>State of Tennessee</b>		16. Telephone number of employer <b>615-741-3590</b>
17. Address of employer (street, city, state, zip) <b>19th Floor William R Snodgrass Blvd. Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, TN 37243</b>		
18. Print name of authorized representative		19. Title
Signature of authorized representative <b>X</b>		Date signed

**PART 2 - CLAIMANT'S STATEMENT - To be completed by the claimant or authorized representative. All questions must be fully completed. Please be sure to sign and date the authorization.**

1. Legal name of claimant (last, first, middle initial)		2. Date of birth (mo/day/yr)
3. Address (street, city, state, zip)		4. Policy number
<input type="checkbox"/> New address?		
5. Social Security number	6. Home telephone number	7. Business telephone number
8. Please describe fully the nature of the disease or injury for which you are claiming benefits		

9. Date you were first treated for your present condition (mo/day/yr)	10. Were you confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>IF YES, PLEASE PROVIDE INFORMATION BELOW.</b>
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11. NAME OF HOSPITAL	ADDRESS OF HOSPITAL	DATE ADMITTED (mo/day/yr)	DATE DISCHARGED (mo/day/yr)
a.			
b.			

12. Name and address of physician(s) who treated you for your current condition	DATE FROM	DATE TO
a.		
b.		
c.		

13. Name and address of physician(s) who treated you within the last 5 years for any cause (If none, please check box <input type="checkbox"/> ).	DATES	CAUSE
a.		
b.		
c.		

14. Are you required by law to use this option of your policy to meet claims of creditors? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. If yes, please explain.
16. Have you filed or do you plan to file for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. If yes, please explain.

18. Are you required by a government agency to use this option of your policy in order to apply for, obtain or keep a government benefit or entitlement? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. If yes, please explain.
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20. If your claim for accelerated benefits is approved, please indicate the percentage or amount you wish to receive

**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 <b>X</b>	Date signed
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**PART 3 - ATTENDING PHYSICIAN'S STATEMENT-To be completed by the physician currently treating you. All questions must be fully completed. Please be sure to sign and date this form. Copies of medical records should also be attached.**

Name of patient

Physician's reference/patient number

**PATIENT HISTORY**

1. Have you treated or advised this patient for any condition during the past 5 years other than current condition?

Yes  No

2. If yes, give diagnosis and dates of treatment (mo/day/yr)

3. Has patient received treatment from another physician? (This would be for time before current condition.)

Yes  No

4. Name and address of physician

**CURRENT CONDITION**

1. Present diagnosis including any complications (describe fully)

Weight

Height

2. Subjective symptoms

3. Objective findings (Including current x-rays, EKG's, laboratory data and any clinical findings)

4. Date of first visit (mo/day/yr)

5. Date of last visit (mo/day/yr)

6. Frequency

Weekly  Monthly  Other (please specify)

**NATURE OF SERVICE**

1. Level of care patient requires or you have authorized

Skilled confinement  Intermediate confinement  Custodial confinement  
 Hospice care  Other (please specify)

2. Give date patient required confinement or hospice care (mo/day/yr)

From \_\_\_\_\_ To \_\_\_\_\_

3. Is confinement or hospice care still required?

Yes  No If no, as of what date (mo/day/yr)

4. Is confinement or hospice care expected to continue until death?

Yes  No If no, how long do you anticipate the confinement or hospice care will be needed?

5. If surgery performed - what type - date of surgery (mo/day/yr)

6. List medications

**PART 3 - ATTENDING PHYSICIAN'S STATEMENT - (CONTINUED)**

**PROGRESS**

1. Patient has...(check one)  Recovered  Improved  Unchanged  Retrogressed

2. If recovered, date of recovery (mo/day/yr)

3. Do you expect a fundamental or marked change in the patient's condition?

Yes-Improvement  Yes-Deterioration  No

4. Is the patient's condition terminal?

Yes  No

5. If yes, what is the patient's life expectancy?

6. Please describe the basis for your life expectancy estimate

7. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?

Yes  No

8. Remarks

Print name of attending physician

Degree

Telephone number

Physician's address (street, city, state, zip)

Print name of person completing this form

Signature of attending physician

Date signed

**X**

**Please Attach Medical Records**