Notice of Accidental Dismemberment and Loss of Sight Claim

securian FINANCIAL®

Minnesota Life Insurance Company - a Securian Financial company
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1-888-658-0193 • Fax 651-665-7106

PART 1 - TO BE COMPLETED BY EMPLOYER

Please review the below New York fraud statement and the attached page for a list of other state-specific fraud statements, and sign and date below.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Employee's name (first, middle, last)	Policy number

Employee date of birth (mo/day/yr)	Date employed (mo/day/yr)	Salary
		$ Per ☐ Hour ☐ Week ☐ Month

Job title	Date last actively worked

Status on last day worked

☐ Full time ☐ Part time If part time, average hours per week:

Amount of Employee's Insurance	Effective Date of Coverage
Basic $ _____	_____
Optional $ _____	_____

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

Name of employer	Employer's telephone number

Employer's address

Signature or electronic signature of authorized representative	Date
X	

PART 2 - CLAIMANT'S STATEMENT - To present your claim for benefits, complete this Claimant's Statement. All questions must be fully completed. Have your physician complete the Attending Physician's Statement and attach copies of your medical records. **Please be sure to sign and date the authorization.**

Claimant's legal name (first, middle, last)	Date of birth (mo/day/yr)	Social Security number

Address (street, city, state, zip)	Telephone number

Date accident occurred	Where accident occurred

Was a police report filed?

☐ Yes ☐ No If yes, please provide a complete copy of the police report.

Did the accident result in dismemberment or total and irrecoverable loss of sight?

☐ Yes ☐ No

Please fully describe the accident

****See Reverse Side****

If the dismemberment, total and irrecoverable loss of sight occurred on a date later than the date of the accident, please list that date.

Name and address of physician treating you	Telephone number
Name and address of hospital	Telephone number

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 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.

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Signature of insured	Date signed
X	

PART 3 - ATTENDING PHYSICIAN'S STATEMENT

Please review the below New York fraud statement and the attached page for a list of other state-specific fraud statements, and sign and date below.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

HISTORY

Patient's name (first, middle, last)	Patient's date of birth
Date accident occurred	Date amputation or loss of sight occurred

Location of accident (work, etc.) Describe:

Has patient ever had same or similar condition or prior disabilities? ☐ Yes ☐ No

At the time of the accident, amputation, or loss of sight, was the patient receiving care or treatment of any disease or illness? ☐ Yes ☐ No

Was the patient's dismemberment, total and irrecoverable loss of sight caused (directly or indirectly) by any physical or mental infirmity; illness or disease; self-inflicted injury: commission of a felony; drugs or poison taken voluntarily; bacterial infection; travel on any military aircraft; or war? ☐ Yes ☐ No

If answers to any of the above questions "yes", describe particulars in detail, including dates.

DISMEMBERMENT

Was there an amputation resulting in severance through or above the wrist or ankle joint? ☐ Yes ☐ No

If "yes", give complete description of dismemberment.

TOTAL AND IRRECOVERABLE LOSS OF SIGHT

Did total and irrecoverable loss of sight occur as a result of the accident? ☐ Yes ☐ No

Did total and irrecoverable loss of sight occur more than 90 days after the accident? ☐ Yes ☐ No

WHAT WAS VISION AT LAST OBSERVATION? (SNELLEN NOTATION)

With glasses	O.D.	O.S.	Date
Without glasses	O.D.	O.S.	Date

DATE CORRECTED VISION WAS IRRECOVERABLY REDUCED TO 20/200 OR LESS IN THE BETTER EYE

Month/day/year

☐ O.D. ☐ O.S.

Vision can be restored in whole or part by:

O.D.	☐ Lenses	☐ Treatment	☐ Operation	☐ Not restorable
O.S.	☐ Lenses	☐ Treatment	☐ Operation	☐ Not restorable

Please enclose copies of any visual fields testing that has been done.

PLEASE INCLUDE COPIES OF YOUR MEDICAL RECORDS PERTAINING TO THE LOSS INCLUDING HOSPITAL ADMISSION AND TOXICOLOGY REPORTS

Name of attending physician (please print)	Degree	Telephone number

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

Signature of attending physician	Date signed	Print name of person completing this form
X		

FRAUD STATEMENTS

For your protection, state laws require the following to appear on this form. Prior to signing this claim form, please review the fraud statement for your state of residence and the state where the insurance policy was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires 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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filling of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.