Notice of Accidental Dismemberment Claim

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

For claim information call:
Toll free 1-800-328-9442
Fax 651-665-7979

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. YOU ARE 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. 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.**

1. Claimant's legal name (last, first, middle initial)	2. Date of birth (mo/day/yr)	3. Social Security number
4. Address (street, city, state, zip)		5. Telephone number ( )
6. Date accident occurred	7. Where did accident occur?	

8. Please fully describe the accident

9. Did the accident result in dismemberment? ☐ Yes ☐ No	10. If the dismemberment occurred on a date later than the date of the accident, please list that date.

11. What physician(s) treated you for this condition?

	Name	Address	Telephone number
a.			
b.			
c.			

12. What hospital(s) treated you for this condition?

	Name	Address	Telephone number
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 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.

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	

PART 2 - ATTENDING PHYSICIAN'S STATEMENT - Please fully complete and **also attach copies of medical records.**

1. Patient's name (last, first, middle initial)	2. Patient's date of birth (mo/day/yr)
3. Date accident occurred (mo/day/yr)	4. Date dismemberment occurred if different from date of accident. (mo/day/yr)

5. Location (work, etc.) and description of accident:

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

7. At the time of the accident, was the patient receiving care or treatment of any disease or illnesss? If yes, please list disease, illness and any medications below. ☐ Yes ☐ No

8. Was the patient's dismemberment 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

Provide details, including dates for any of the above questions answered "yes".

DISMEMBERMENT: Please fully describe the accident and dismemberment.

PLEASE INCLUDE COPIES OF YOUR MEDICAL RECORDS PERTAINING TO THE LOSS

Name of attending physician (please print)	Degree	Telephone number ( )

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

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

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