Notice of Accidental Loss - Claimant Statement

Minnesota Life Insurance Company - a Securian Financial company
Benefit Services • P.O. Box 64114, St. Paul, MN 55164-0114
1-888-658-0193 • Fax 1-877-494-8401

CLAIM NUMBER

To present your claim for your accidental loss, complete this Claimant Statement. All questions must be fully completed. Have 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 the Attending Physician Statement been fully completed and signed by your attending physician?
- ☐ Has the authorization been signed and dated by the claimant or their authorized representative?
- ☐ Are copies of medical records attached?

Claimant Information

Claimant's legal name (first, middle, last)	Date of birth (mo/day/yr)
Address (street)	Telephone number

Address (city, state, zip)

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

Describe the accident that caused your loss

Date accident occurred (mo/day/yr)	Where did the accident occur?

Did the loss occur on the same date as the accident?
☐ Yes ☐ No If no, please provide the date the loss occurred (mo/day/yr):

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

****See Reverse Side****

Treatment History

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.		Dates (mo/day/yr)
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.

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institution, employer, workers' compensation, rehabilitation facility, any other health care provider that has provided payment, treatment or services, or any other organization or person which has any medical or nonmedical records or knowledge, to disclose and release the entire medical record and any other protected information (such as physical health, mental health, financial information and employment) concerning the above named individual to Minnesota Life Insurance Company (the Company) and its agents, employees, and representatives. This includes the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signature below, I acknowledge that any agreements I have made to restrict the protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that the Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage applied for with the Company.

This authorization shall remain in force for 24 months following the date of the signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at the above listed address. I understand that a revocation is not effective to the extent that any of the providers has relied on this authorization or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release the complete medical record, the Company may not be able to process the submitted claims and may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

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

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.

SIGN HERE >	**Signature of claimant**	Date signed (mo/day/yr)
	X	

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

SIGN HERE

Signature of claimant X	Date signed (mo/day/yr)

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.

How would you like to receive the proceeds payable to you?
Alaskan residents: you may receive funds more quickly if you select the direct deposit option, as check payment(s) to Alaskan payees require additional processing time.

☐ Check - if you select this option, you do not need to complete Direct Deposit Information section
☐ Direct deposit - if you select this option, you must complete Direct Deposit Information section

Direct Deposit Information - Benefits 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.

Authorization for Direct Deposit

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.

Account type ☐ Savings (attach deposit slip) ☐ Checking (attach voided check)	Bank routing/transit number	Account number

SIGN HERE

Signature of claimant X	Date signed (mo/day/yr)

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.