Notice of Death

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

ADMINISTRATOR'S STATEMENT: Complete Parts 1, 2 and 4 if employee dies. Complete Parts 1, 3 and 4 if dependent dies. Attach a certified copy of the official death certificate.

PART 1 - EMPLOYEE INFORMATION

1. Employer/policyholder name	2. Branch location/unit number (if applicable)	3. Plan/policy number

4. Employee name (last, first, middle name)

5. Other names by which the deceased has been known, if any	6. Employee address (street, city, state, zip)

7. Employee Social Security number	8. Employee date of birth (mo/day/yr)	9 Employee telephone number

10. Employee date of hire (mo/day/yr)	11. Effective date of employee's insurance (mo/day/yr)	12. Employee actively at work on effective date? ☐ Yes ☐ No

PART 2 - DECEASED EMPLOYEE (If enrollment cards are maintained in your office, attach a copy of the employee's card.)

WITHOUT A COMPLETED IRS FORM W-9 BY THE BENEFICIARY, THE BENEFICIARY MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.

1. Last date deceased was actively at work performing normal duties (mo/day/yr)	2. Reason deceased stopped actively working	3. Date of death (mo/day/yr)

4. Date employer's unit entered group insurance plan (mo/day/yr)	5. Date to which premiums were paid for deceased (mo/day/yr)

6. Beneficiary as recorded on records of employer	Address (street, city, state, zip) and daytime telephone number of beneficiary	Relationship to employee	Beneficiary's Social Security number	Beneficiary's age
a.				
b.				
c.				

7. Amount of insurance (if based on salary, complete salary information)	8. Salary on date last worked	9. Effective date of that salary
$	$	

PART 3 - DECEASED DEPENDENT (If enrollment cards are maintained in your office, attach a copy of the employee's card.)

WITHOUT A COMPLETED IRS FORM W-9 BY THE EMPLOYEE, THE EMPLOYEE MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.

1. Deceased dependent's Social Security number	2. Is employee still actively working? ☐ Yes ☐ No	3. Marital status of dependent ☐ Single ☐ Married ☐ Divorced ☐ Widowed

4. Name of insured dependent	5. Relationship to employee

6. Duration of final illness or date dependent became confined to hospital or home	7. Date of birth of dependent (mo/day/yr)	8. Date of death of dependent (mo/day/yr)

9. Effective date of dependents insurance (mo/day/yr)	10. Date premiums for dependent's coverage paid to (mo/day/yr)	11. Amount of insurance
		$

PART 4 - CERTIFICATION I certify that on the date of death, the above named was insured under this policy. I further certify that the information provided above is true and correct to the best of my knowledge and belief.

1. Name of employer, association or fund	2. Telephone number
	( )

3. Address of employer, association or fund (street, city, state, zip)

4. Signature of authorized representative	Date signed	Title
X		

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.