Clear form

Notice of Claim for Accelerated Benefit

Minnesota Life Insurance Company - a Securian Financial company
Benefit Services • PO Box 64114, St. Paul, MN 55164-0114
1-888-658-0193 • Fax 651-665-7106

securian FINANCIAL®

To present your claim under the accelerated benefit option of your policy, please fully complete this form.

CLAIM NUMBER

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. If enrollment applications are maintained in your office, please attach a copy.

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.

Employee's name (first, middle, last)		Policy number **34259**
Claimant's address (street, city, state, zip)		Date of birth (mo/day/yr)
Date of hire (mo/day/yr)	Effective date of insurance (mo/day/yr)	
Is employee still actively working? ☐ Yes ☐ No If no, date employee last actively worked (mo/day/yr):		
Reason for employment termination on date last worked ☐ Temporary layoff ☐ Leave of absence ☐ Disability ☐ Retirement ☐ Not applicable, actively working ☐ Other, please explain:		
Date to which premiums paid (mo/day/yr)	Employee's amount of insurance **$**	
If based on salary, provide salary on date last worked **$**	Effective date of that salary (mo/day/yr)	
Please complete dependent information only if claim is for a dependent. Name of insured dependent		Relationship to employee ☐ Spouse ☐ Child
Dependent's amount of insurance **$**	Effective date of dependent's coverage (mo/day/yr)	
Name of employer **Pasadena Independent School District**		Telephone number of employer
Address of employer (street, city, state, zip)		
Print name of authorized representative		Title
Signature or electronic signature of authorized representative **X**		Date signed

Securian Financial is the marketing name for Minnesota Life Insurance Company. Insurance products are issued by Minnesota Life Insurance Company.

CLAIM NUMBER

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.

Legal name of claimant (first, middle, last)		Date of birth (mo/day/yr)
Address (street, city, state, zip) ☐ New address?		Policy number 34259
Social Security number	Home telephone number	Business telephone number

Please describe fully the nature of the disease or injury for which you are claiming benefits

Date you were first treated for your present condition (mo/day/yr)

Were you confined to a hospital?

☐ Yes ☐ No **IF YES, PLEASE PROVIDE INFORMATION BELOW.**

Name of Hospital	Address of Hospital	Date Admitted (mo/day/yr)	Date Discharged (mo/day/yr)
a.			
b.			

Name and address of physician(s) who treated you for your current condition	Date From	Date To
a.		
b.		
c.		

Name and address of physician(s) who treated you within the last 5 years for any cause (If none, please check box ☐.)	Dates	Cause
a.		
b.		
c.		

Are you required by law to use this option of your policy to meet claims of creditors?

☐ Yes ☐ No If yes, please explain.

Have you filed or do you plan to file for bankruptcy?

☐ Yes ☐ No If yes, please explain.

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?

☐ Yes ☐ No If yes, please explain.

If your claim for accelerated benefits is approved, please indicate the percentage or amount you wish to receive

% or $

CLAIMANT'S STATEMENT Continued on Next Page

PART 2 - CLAIMANT'S STATEMENT - (CONTINUED)

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.

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.

Signature of insured	Date signed
X	

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.

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.

Name of patient (first, middle, last)	Physician's reference/patient number	**CLAIM NUMBER**

PATIENT HISTORY

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

☐ Yes ☐ No

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

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

☐ Yes ☐ No

Name and address of physician

CURRENT CONDITION

Present diagnosis including any complications (describe fully)	Weight	Height

Subjective symptoms

Objective findings (Including current x-rays, EKGs, laboratory data and any clinical findings)

Date of first visit (mo/day/yr)	Date of last visit (mo/day/yr)

Frequency

☐ Weekly ☐ Monthly ☐ Other (please specify):

ATTENDING PHYSICIAN'S STATEMENT Continued on Next Page

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

NATURE OF SERVICE

Level of care patient requires or you have authorized

CLAIM NUMBER

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

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

From To

Is confinement or hospice care still required?

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

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?

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

List medications

PROGRESS

Patient has (check one)

☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

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

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

☐ Yes-Improvement ☐ Yes-Deterioration ☐ No

Is the patient's condition terminal? ☐ Yes ☐ No	If yes, what is the patient's life expectancy?

Please describe the basis for your life expectancy estimate

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

☐ Yes ☐ No

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 **X**		Date signed

Please Attach Medical Records

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.