

# 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. Group ID number	3. Plan/policy number <b>34407</b>
4. Employee name			
5. Employee BIN # (the BIN is available through the subscriber inquiry screen on EBS)			
6. Other names by which the deceased has been known, if any		7. Employee address (street, city, state, zip)	
8. Employee Social Security number	9. Employee date of birth (mo/day/yr)	10. Employee telephone number	
11. Employee date of hire (mo/day/yr)	12. Effective date of employee's insurance (mo/day/yr)	13. Employee actively at work on effective date? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## PART 2 - DECEASED EMPLOYEE

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 \$				

**\*\*Include NOE, beneficiary designation, and subscriber inquiry showing current coverage\*\***

## PART 3 - DECEASED DEPENDENT

1. Deceased dependent's Social Security number	2. Is employee still actively working? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Marital status of dependent <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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 \$		

**\*\*Include NOE and subscriber inquiry showing current coverage\*\***

**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)	

Signature of authorized representative <b>X</b>	Date signed	Title
--	-------------	-------

**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.