Waiver of Premium Claim
Employer's Statement

Minnesota Life Insurance Company, a Securian Financial Group affiliate • Group Division Claims
Charleston Branch Office • PO Box 3742 • Charleston, WV 25337-3742 • Toll free 1-800-203-9515

MINNESOTA LIFE

Type of Claim: ☐ **Active Employee** ☐ **Retiree**

Policyholder's name	Policy number	Account number	Coverage code
PEIA	**33227**		

Insured employee's name (Last, First, Middle Initial)	Employee ID	Gender
		☐ Male ☐ Female

Street address

Date of birth (Month, Day, Year)	Date employed (Month, Day, Year)	Social Security number

Job title	Date last worked

Status on employment date ☐ Full time ☐ Part time If part-time, average hours per week. _____

Amount of Employee's Insurance	Effective Date of Coverage
Basic $ _____	_____

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

Name of employer	Employer's telephone number

Employer's address

Authorized signature	Date
X	

Notice of Disability

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MINNESOTA LIFE

CLAIMANT'S STATEMENT. *To present your claim for benefits, complete the Claimant's Statement. All questions must be fully completed.*

PLEASE BE SURE TO SIGN AND DATE THE AUTHORIZATION ON THE REVERSE SIDE.

Policyholder	Policy number
PEIA	**33227**

1. Claimant's legal name (Last, First, Middle Initial) | 2. Telephone number ( )

3. Permanent address (Street, City, State, Zip)

4. Height	5.Weight	6. Date of birth (Mo/Day/Yr)	7. Gender ☐ Male ☐ Female

8. What was your occupation prior to your disability | 9. Date of employment

10. Employer's name | 11. Supervisor's name

12. Employer's address (Street, City, State, Zip) | 13. Telephone number ( )

14. Describe fully the duties you performed in that occupation

15. What was your annual income from your occupation prior to your disability $	16. What is it now $	17. Social Security number

18. Circle the number of years you have completed in

GRADE SCHOOL 1 2 3 4 5 6 7 8 HIGH SCHOOL 9 10 11 12 GED COLLEGE 1 2 3 4 VOCATIONAL TRAINING 1 2 3

19. What degrees do you hold

20. Are you receiving Social Security, Civil Service, armed forces or any other disability benefit
☐ Yes ☐ No If so, from what source

21. What special skills do you have

22. Past occupation job titles (List all prior jobs) If none, please check box ☐	Starting employment dates	Ending employment dates	Job duties

23. On what date did your injury occur or disability commence	24. On what date did you last actively perform the duties of your job
25. Are you now totally disabled and unable to perform your job ☐ Yes ☐ No	26. Will your disability be permanent ☐ Yes ☐ No
27. If no, when will you resume all or part of your work	28. If part, what duties

29. Describe fully the nature of the disease or injury causing your disability

30. Are you currently enrolled in a vocational rehabilitation program ☐ Yes ☐ No	31. If yes, list counselor's name, address and telephone number	32. If you are not currently enrolled, do you plan to attend a rehabilitation program in the future ☐ Yes ☐ No

When did you first consult a physician for your disability

WHAT PHYSICIANS HAVE TREATED YOU FOR YOUR DISABILITY

Name (Last, First, Middle Initial)	Address (Street, City, State, Zip)	Telephone number
Diagnosis		Date (Mo/Day/Yr)
Name (Last, First, Middle Initial)	Address (Street, City, State, Zip)	Telephone number
Diagnosis		Date (Mo/Day/Yr)
Name (Last, First, Middle Initial)	Address (Street, City, State, Zip)	Telephone number
Diagnosis		Date (Mo/Day/Yr)

DATES OF HOSPITALIZATIONS

From / To	Hospital name	
From / To	Hospital name	
Hospital address		Telephone number
Hospital address		Telephone number

DESCRIBE FULLY ANY WORK YOU ARE NOW DOING OR YOUR CURRENT DAILY ACTIVITIES AND ANY REMARKS

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 and test results.

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.

I AUTHORIZE: Minnesota Life Insurance Company to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the names of the companies but does not contain medical or other personal information. I understand **Minnesota Life Insurance Company** will report to MIB the date(s) of any past or present clams filed by me.

Upon receipt of a request from me, MIB will arrange a disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is PO Box 105, Essex Station, Boston MA 02112, telephone number (617) 426-3660.

This authorization shall be valid for 24 months from 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	

Minnesota Life
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Attending Physician's Statement

FC 21

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MINNESOTA LIFE

For Home Office use only:

- ☐ Please have this form completed immediately.
- ☐ Please have this form completed on or after _____ .
- ☐ Please have this form completed on _____ or upon recovery if sooner.
- ☐ If the claimant remains disabled beyond _____ and wish further consideration of your claim, please have this completed on _____ or upon recovery if sooner.

CLAIM NUMBER:

The insured is responsible for the completion of this form. You may mail this form directly to the Home Office of the Company. Both sides of this form must be fully completed by the attending physician.

Patient's name (Last, First, Middle Initial)	Telephone number ( )

Date of birth (Mo/Day/Yr)	Height	Weight	Blood pressure reading/date

HISTORY

1. Date symptoms first appeared or accident occurred	2. Date patient ceased work due to disability	3. Is condition due to injury or illness arising out of patient's employment? If yes, check one ☐ Yes ☐ No ☐ Injury ☐ Illness

4. Has patient ever had same or similar condition? If yes, state when and describe.
☐ Yes ☐ No

5. Names and addresses of other treating physicians

DIAGNOSIS

1. Diagnosis including any complications for current condition	2. Patient account/file number

3. Subjective symptoms

4. Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

NATURE AND DATES OF SERVICE

1. Date (Mo/Day/Yr) of first visit	2. Date (Mo/Day/Yr) of last visit	3. Date (Mo/Day/Yr) of next visit	4. Frequency

5. Has patient been hospitalized? If yes, give dates.
☐ Yes ☐ No From _____ through _____

6. Was surgery performed? If yes, state when and describe.
☐ Yes ☐ No

7. Name and address of hospital

8. Is the patient currently enrolled in any type of rehabilitation program? ☐ Yes ☐ No

9. If yes, what type of program? ☐ Cardiac ☐ Physical therapy ☐ Other _____

10. List medications

SEE REVERSE SIDE

CARDIAC Functional capacity (American Heart Association)

CLAIM NUMBER:

☐ CLASS 1 (No limitation) ☐ CLASS 2 (Slight limitation) ☐ CLASS 3 (Marked limitation) ☐ CLASS 4 (Complete limitation)

1. Describe the basis for above classification

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work. *No restrictions (0 - 10%).
☐ Class 2 – Medium manual activity* (15 - 30%).
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35 - 55%).
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administration (sedentary*) activity (60 - 70%).
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75 - 100%).

1. List all restrictions and describe the basis for above classification

MENTAL/NERVOUS IMPAIRMENT

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation).
☐ Class 5 – Patient has significant loss of psychological, personal and social adjustment (severe limitations).

1. Describe the basis for above classification

2. Do you feel this patient is competent to endorse and direct the use of proceeds thereof?

☐ Yes ☐ No

PROGRESS

1. Patient has . . . (check all that apply) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed ☐ Reached maximum medical improvement - impairment rating of _____ %

2. If recovered, date (Mo/Day/Yr) released to return to work.

3. Patient is . . . (check one) ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

4. Patient is a suitable candidate for ☐ Trial employment ☐ Full-time ☐ Part-time ☐ Work hardening ☐ Job retraining

PROGNOSIS	REGULAR WORK	OTHER WORK
1. Is patient now totally disabled?	☐ Yes ☐ No If no, date released _____	☐ Yes ☐ No If no, date released _____
2. Do you expect a change in the future relating to patient's ability to work?	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No
a) If improvement is expected, when will patient recover sufficiently to perform duties?	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____

b) If no, please explain.

Remarks

Have you provided information for this patient for another insurance company or agency?

☐ Yes ☐ No If yes, list company/agency name, telephone number and claim number.

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

Physician's address (Street, City, State, Zip)

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

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