# 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 |
|---|---|---|
| | | 34407 |

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? |
|---|---|---|
| | | ☐ Yes ☐ 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 and beneficiary designation****

## PART 3 - DECEASED DEPENDENT

| 1. Deceased dependent's Social Security number | 2. Is employee still actively working? | 3. Marital status of dependent |
|---|---|---|
| | ☐ Yes ☐ No | ☐ 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 |
|---|---|---|
| | | $ |

****Include NOE****

## 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 | 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.