Notice of Disability
Lender and Claimant and Physician Statement

FC 35

Minnesota Life Insurance Company - A Securian Company
Claims • P.O. Box 64270 • St. Paul, MN 55164-0270

For claim information call:
Toll free 1-888-672-6850
Fax 513-947-4044

MINNESOTA LIFE

IMPORTANT: PARTS 1, 2, AND 3 MUST BE FULLY COMPLETED BEFORE SUBMITTING THIS CLAIM.

PART 1 - LENDER'S STATEMENT - To be completed by lender

1. Legal name of claimant

2. Address of claimant (street, city, state, zip)

3. Date disability began (mo/day/yr)	4. Last day claimant actively worked	5. Were all payments current on the date of disability? ☐ Yes ☐ No

I - ATTACHMENT REQUEST

1. Verification of Coverage:
We need information to verify the insurance coverage. **Please send a copy of all insurance applications for this insured.**

II - GENERAL LOAN INFORMATION - Please complete for all loans. (Please complete another form if more than three loans.)

	LOAN 1	LOAN 2	LOAN 3
6. ☐ SINGLE PREMIUM CHARGED ☐ MONTHLY PREMIUM CHARGED	Date last charged (mo/day/yr)	Date last charged (mo/day/yr)	Date last charged (mo/day/yr)
7. LOAN NUMBER			
8. DATE OF ORIGINAL LOAN (mo/day/yr)			
9. PRINCIPAL BALANCE ON DATE DISABILITY BEGAN	$	$	$
10. APR ON LOAN (if variable, APR on date disability began)	Variable ☐ Yes ☐ No	Variable ☐ Yes ☐ No	Variable ☐ Yes ☐ No
11. PAYMENT MODE/AMOUNT	☐ Monthly $_____ ☐ Semimonthly ☐ Weekly ☐ Biweekly	☐ Monthly $_____ ☐ Semimonthly ☐ Weekly ☐ Biweekly	☐ Monthly $_____ ☐ Semimonthly ☐ Weekly ☐ Biweekly

III - CLOSED END LOANS ONLY - Please complete for Closed End Loans.

12. TERM OF LOAN			
13. SCHEDULED MATURITY DATE (mo/day/yr)			
14. FIRST PAYMENT DATE (mo/day/yr)			
15. ORIGINAL AMOUNT OF LOAN	$	$	$
16. Is the loan a refinance of a previously insured loan? If yes, please submit copies of the current and previous loan notes and insurance applications.	☐ Yes ☐ No If yes, previous loan number? Previous loan effective date.	☐ Yes ☐ No If yes, previous loan number? Previous loan effective date.	☐ Yes ☐ No If yes, previous loan number? Previous loan effective date.

IV - OPEN END LOANS ADVANCES ONLY - Please complete for Open End Loans. (List all advances made within six months prior to onset of disability. You may attach loan history for advance information. If none, check box ☐)

DATE OF ADVANCE			
AMOUNT OF ADVANCE	$	$	$
DATE OF ADVANCE			
AMOUNT OF ADVANCE	$	$	$
DATE OF ADVANCE			
AMOUNT OF ADVANCE	$	$	$
DATE OF ADVANCE			
AMOUNT OF ADVANCE	$	$	$

I certify that the information above is true and correct to the best of my knowledge.

Name of lending institution	Policy number (and unit number if applicable)

Address (street, city, state, zip)

Name of authorized representative	Telephone number	Extension

Email address

Signature of authorized representative	Date signed
X	

PART 2 - CLAIMANT'S STATEMENT *To present your claim for benefits, complete this Claimant's Statement. All questions must be fully completed.* **If all questions are not fully completed, this may result in additional handling, which could delay your claim. Please sign and date the authorization below.**

1. Legal name of claimant	2. Social Security number	3. ☐ Male ☐ Female	4. Date of birth (mo/day/yr)

5. Mailing address (street, city, state, zip)	6. Home telephone number

7. Name of lending institution	8. Account/loan number	9. Job title at time of disability	10. Hours worked each week

11. Self employed ☐ Yes ☐ No	Name and address of business	Date business began (mo/day/yr)	Business license number

12. Describe your job duties	13. Date of hire (mo/day/yr)

14. Employer's name	15. Employer's address (street, city, state, zip)	16. Employer's telephone number	Ext.

17. Is your disability the result of illness? ☐ Yes ☐ No	18. Date illness began? (mo/day/yr)	19. Date first treated for current illness (mo/day/yr)

20. Is your disability the result of an accidental injury? ☐ Yes ☐ No	21. Date of accident/ injury (mo/day/yr)	22. Date first treated for injury (mo/day/yr)	23. Cause of accident/injury ☐ Motor vehicle accident ☐ Work related injury ☐ Other

24. Describe your illness or injury

25. Date you stopped work due to disability (mo/day/yr)	26. Have you missed work for this condition in the past? ☐ Yes ☐ No	27. If yes, give dates you missed work. From To

28. Have you returned to work? ☐ Yes ☐ No	Date returned (mo/day/yr)	Number of hours you are working each week	29. Did you return to work with restrictions? ☐ No ☐ Yes If yes, describe.

30. What physician(s) treated you for your **current disability?**

	Name	Address	Telephone number	Dates
a.				
b.				

31. Who is your family physician? (If none, please check box ☐.)

	Name	Address	Telephone number	Dates	Reason
a.					

32. What physician(s) treated you within **the last 5 years** for any cause? (If none, please check box ☐.) (Attach an additional sheet of paper if necessary.)

	Name	Address	Telephone number	Dates	Reason
a.					
b.					
c.					

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.

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.

Signature of insured	Date signed
X	

PART 3 - ATTENDING PHYSICIAN'S STATEMENT *Must be **fully** completed before benefits can be considered.*

1. Describe fully, diagnosis and concurrent conditions for current disability (if multiple diagnoses, indicate which diagnoses are disabling in and of themselves)	2. Patient's account or file number

3. Date condition or symptom first appeared	4. Date you were first consulted for this condition

5. List all dates of treatment for this condition

6. Next scheduled appointment	7. Dates of hospitalization From To	8. Was surgery performed? ☐ Yes ☐ No Date Type of surgery

9. Was patient referred to you by another physician? ☐ Yes ☐ No	10. Name of referring physician and telephone number

11. Dates patient was unable to work due to disability From To	12. Date patient able to return to work (or estimate date)	13. If still disabled, when will patient recover sufficiently to perform duties of his/her regular work? ☐ 1 Mo ☐ 2-3 Mo ☐ 4-6 Mo ☐ Never ☐ Other

14. Has patient been treated for this condition within the past two years? ☐ Yes ☐ No	15. By whom? Name of physician and telephone number

16. Have you treated/advised this patient for **any** condition during the past five years? ☐ Yes ☐ No	17. If yes, please give diagnosis and dates of treatment.

18. Is patient still under your care? ☐ Yes ☐ No	19. Name and telephone number of physician you have referred patient to	20. Date referred

Print or type attending physician's name and complete address	Telephone number	Fax number

Print name of person completing this form	Physician's signature	Degree	Date signed
	X		

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