Beneficiary Statement

Minnesota Life Insurance Company - A Securian Company
Claims • P. O. Box 64114 • St. Paul, MN 55164-0114

For claim information call:
Toll free 1-888-658-0193
Fax 651-665-7106

MINNESOTA LIFE

PART 1 – All fields must be completed in Part 1 including your signature

Name of deceased	Policy number	**CLAIM NUMBER**

Other names by which the deceased has been known, if any

Address prior to death (street, city, state, zip)

Date of birth (mo/day/yr)	Date of death (mo/day/yr)	Date last worked (mo/day/yr)

Name of beneficiary

Relationship to deceased	Beneficiary's date of birth

CERTIFICATION INSTRUCTIONS: You must cross out item (2) below if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

CERTIFICATION – Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct Social Security number or Taxpayer Identification number, **and**
(2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to backup withholding, **and**
(3) I am a U. S. person (including a U. S. resident alien), **and**
(4) The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.
Exempt payee code (if any)_____ Exemption from FATCA reporting code (if any)_____

Certification Notice:
THE IRS REQUIRES US TO OBTAIN CERTIFICATION OF YOUR SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER. WITHOUT THIS INFORMATION, YOU MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING FOR ANY INTEREST PAID ON THE DEATH BENEFIT.

Signature of beneficiary	Date signed	Beneficiary's Social Security number
X		

Current address of beneficiary (street, city, state, zip)	Beneficiary's telephone number

Permanent address of beneficiary (if different than above)

A **CERTIFIED** COPY OF THE PUBLIC DEATH RECORD IS REQUIRED AS PROOF OF DEATH

PART 2 – PAYMENT INFORMATION (Benefits will be sent to you via a check if Part 2 is not fully completed and signed.)

How would you like to receive the proceeds payable to you?

☐ Check ☐ Direct Deposit - if you select this option, you must complete and sign the bottom of this form.

Authorization for Direct Deposit

I authorize Minnesota Life Insurance Company ("Company") to initiate deposits (credit entries) and corrections (debit entries) to adjust any deposits made in error to my account indicated below. I authorize the financial institution ("Depository") named below to accept these deposits and/or corrections made to this account.

This authorization is to remain in full force and effect until Company has received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on it or until such time as Company terminates this method of payment.

Name of depository (bank, credit union, etc.)			Depository telephone number
Street	**City**	**State**	**Zip code**

Account type ☐ Savings ☐ Checking	Bank routing/transit number	Account number

IMPORTANT: For purposes of accuracy, **PLEASE ATTACH A VOIDED CHECK OR SAVINGS DEPOSIT SLIP.**

Signature of beneficiary	Date signed
X	

PART 3 – NOTICE

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.