Waiver of Premium Claim
Employer's 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

Policyholder's name	Policy number	Branch location/unit number

Insured employee's name (last, first, middle name)	Gender
	☐ Male ☐ Female

Street address

Date of birth (mo/day/yr)	Date employed (mo/day/yr)	Social Security number

Job title	Date last worked	Salary
		$ Per ☐ Hour ☐ Week ☐ Month ☐ Year

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	$ _____	_____
Optional	$ _____	_____
Spouse	$ _____	_____
Child	$ _____	_____
Other	$ _____	_____

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 (street, city, state, zip)

Name of authorized representative	Email address	Telephone number

Authorized signature	Date
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.