

Beneficiary Statement



Securian Financial Group, Inc.
 Minnesota Life Insurance Company
 Benefit Services • P.O. Box 64114, St. Paul, MN 55164-0114
 1-888-658-0193 • Fax 1-877-494-8401

CLAIM NUMBER

This form must be completed in order to claim benefits for a life insurance policy. Please fully complete this form, including your Social Security number or Tax Identification number and signature as required by the IRS. If you are assisting the beneficiary with the completion of this form, please attach documentation that supports your ability to act on behalf of the beneficiary (e.g. Power of Attorney documents, court issued guardianship, etc.).

Decedent's Information

Name of deceased (first, middle, last) _____

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

Date of birth (mo/day/yr)	Date of death (mo/day/yr)	Date last worked (mo/day/yr) if unknown or retired mark n/a
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Beneficiary Information - review certification and complete all fields, including your signature

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.

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).

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 this benefit.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Enter your Taxpayer Identification number in the appropriate box. For individuals and sole proprietors, this is your Social Security number. For other entities including estates and trusts, it is your Tax Identification number.

Beneficiary Social Security number +	OR	Tax Identification number +
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Name of beneficiary (first, middle, last)	Beneficiary's date of birth (mo/day/yr)
Mailing address (street)	Beneficiary's telephone number
City, state, zip	Relationship to deceased
Email address (optional)	

By furnishing this form or any other form, the Company does not admit that any coverage is in force nor waive any of its rights or defenses.

****See Reverse Side****

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

- Check - I'd like a paper check sent via U.S. Mail.**
- Direct Deposit - if you select this option, you must complete the following section:**

Authorization for Direct Deposit

By electing this option and providing the account information below, 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 on the attached voided check/deposit slip, 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.

Benefits will not be deposited directly but will be sent to you via a check in any of the following situations: a) Authorization for Direct Deposit not completed; b) a voided check or deposit slip is not provided; c) we are unable to process the direct deposit.

Account type <input type="checkbox"/> Savings (attach deposit slip) <input type="checkbox"/> Checking (attach voided check)	Bank routing/transit number	Account number
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By signing below, I attest that the information provided is true and accurate to the best of my knowledge and belief, and I request that the Company proceed with payment of the claim pursuant to the information above.

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.

SIGN HERE >	Signature of beneficiary	Date signed (mo/day/yr)
	X	

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