Notice of Death

Minnesota Life Insurance Company, a Securian Financial Group affiliate • Refer completed Claims to:
Public Employee Insurance Agency • Capital Complex • Building 5, 10th floor • Charleston, WV 25305-0710
Toll free 1-888-680-7342

MINNESOTA LIFE

EMPLOYEE'S STATEMENT: Complete Parts 1 and 2 if employee dies. Complete Parts 1 and 3 if dependent dies. Attach a certified copy of the official death certificate.

Type of Claim: ☐ **Active Employee** ☐ **Retiree** ☐ **Dependent**

PART 1 - EMPLOYEE INFORMATION

1. Employee last name	2. Employee first name	3. Employee middle name
4. Other names by which the deceased has been known, if any	5. Employee address (street, city, state, zip)	
6. Employee Social Security number	7. Employee date of birth (mo/day/yr)	8. Employee telephone number ( )
9. Employee date of hire (mo/day/yr)	10. Effective date of employee's insurance (mo/day/yr)	11. Employee actively at work on effective date? ☐ Yes ☐ No

PART 2 - DECEASED EMPLOYEE *(WITHOUT A COMPLETED IRS FORM W-9 BY THE BENEFICIARY, THE BENEFICIARY MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.)*

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. Was death due to an accident? ☐ Yes ☐ No

PART 3 - DECEASED DEPENDENT *(WITHOUT A COMPLETED IRS FORM W-9 BY THE EMPLOYEE, THE EMPLOYEE MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING ON INTEREST PAID.)*

1. Deceased dependent's Social Security number	2. Marital status of dependent ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
3. Name of insured dependent	4. Relationship to employee	
5. Date of birth of dependent (mo/day/yr)	6. Date of death of dependent (mo/day/yr)	
7. Effective date of dependents insurance (mo/day/yr)	8. Were premiums (mo/day/yr) for dependents coverage paid to date of death? ☐ Yes ☐ No	9. Amount of insurance $

PART 4 - EMPLOYER'S CERTIFICATION

1. Name of employer, association or fund		2. Telephone number ( )
3. Address of employer, association or fund (street, city, state, zip)		4. Account number
5. Signature of authorized representative X	Date signed	Title

PART 5 - PEIA 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. (Attach a copy of enrollment form.)

1. Employer/policyholder name	2. Coverage code	3. Plan/policy number	4. Date to which premiums were paid for deceased (mo/day/yr)
PEIA		33227	

5. Beneficiary as recorded on records of employer (if none on file, indicate "none")	Current address (street, city, state, zip) and daytime telephone number of beneficiary (if different than listed on designation)	Relationship to employee	Beneficiary's Social Security number	Beneficiary's age
a.				
b.				
c.				

6. Amount of insurance
Basic $_____ AD&D $_____ Optional $_____ Optional AD&D $_____

7. Signature of authorized PEIA representative X	Date signed	Telephone number ( )

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. 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.