Notice of Claim
Virginia Retirement System

securian FINANCIAL™

Securian Financial Group, Inc.
Minnesota Life Insurance Company
Richmond Branch Office • P.O. Box 1193, Richmond, VA 23218-1193
1-800-441-2258 • Fax (804) 644-2460

CLAIM NUMBER

Policy number	Policy number	
Name of insured employee	Date of birth	Social Security number
Insured's address (street, city, state, zip)	Date of hire	Employer code number

Type of Claim

☐ Death ☐ Accidental death
☐ Accidental dismemberment
☐ Accelerated benefit

☐ Active employee ☐ Disabled employee ☐ Spouse ☐ Child
☐ Disabled retiree (disability Retirement) Retirement date: _____
☐ Retiree (regular service retirement) Retirement date: _____

Deceased's Information (If Accelerated Benefit or Dismemberment claim, please indicate name of claimant)

Name of deceased/claimant	Social Security number	Date of birth (mo/day/yr)
Name of contact	Relationship to deceased/claimant	Telephone number of contact

Address of contact (street, city, state, zip)

Date of death/loss	State of death

Insurance Information

Type of coverage	Effective date	Amount
Basic Life		$
Optional Life	Option? ☐ 1 ☐ 2 ☐ 3 ☐ 4	$
Spouse		$
Child		$
Premium paid to date	Last day actively at work	Annual salary on last day worked $

Beneficiary Information - Please complete the beneficiary information below for death claims only.

Was the beneficiary designated?

☐ Beneficiary designated ☐ None designated (If no beneficiary designated, follow the policy's order of priority.)

Beneficiary name	Relationship to employee	Age	Social Security number
Address (street, city, state, zip)			Telephone number
Beneficiary name	Relationship to employee	Age	Social Security number
Address (street, city, state, zip)			Telephone number

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****

Beneficiary name	Relationship to employee	Age	Social Security number
Address (street, city, state, zip)			Telephone number
Beneficiary name	Relationship to employee	Age	Social Security number
Address (street, city, state, zip)			Telephone number

Certification - I certify that on the date of death/loss, 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.

Employer (name of department, institution, agency, school board, etc.)	Telephone number
Address (street, city, state, zip)	Title of representative

Printed name of representative completing this form

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 authorized representative** X	Date signed (mo/day/yr)

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