MINNESOTA LIFE

VIRGINIA RETIREMENT SYSTEM
NOTICE OF CLAIM

Group Division Claims ● P.O. Box 1193 ● Richmond, VA 23218-1193 ● FOR INFORMATION CALL: Toll Free (800) 441-2258

POLICY NUMBER	POLICY NUMBER
29413 Basic	**29414 Optional Life & Spouse / Child Life**

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	☐ ACTIVE EMPLOYEE ☐ DISABLED EMPLOYEE ☐ SPOUSE ☐ CHILD
☐ ACCIDENTAL DISMEMBERMENT	☐ DISABLED RETIREE (DISABILITY RETIREMENT) _____ RETIREMENT DATE
☐ ACCELERATED BENEFIT	☐ RETIREE (REGULAR SERVICE RETIREMENT) _____ RETIREMENT DATE

Please indicate name of deceased. If Accelerated Benefit or Dismemberment claim, please indicate name of claimant.

NAME OF DECEASED/CLAIMANT	DECEASED/CLAIMANT'S SOCIAL SECURITY NUMBER	DECEASED/CLAIMANT'S DATE OF BIRTH
NAME OF CONTACT	**RELATIONSHIP TO DECEASED/CLAIMANT**	**DATE OF DEATH OR LOSS**
ADDRESS OF CONTACT		**TELEPHONE NUMBER OF CONTACT**

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 $ _____

(Please complete the beneficiary information below for death claims only.)

BENEFICIARY: (Please indicate which) ☐ Beneficiary designated ☐ None designated

(If no beneficiary designated, follow the policy's order of priority.)

BENEFICIARY NAME	COMPLETE ADDRESS & TELEPHONE NUMBER	RELATIONSHIP	SOCIAL SECURITY NUMBER	AGE

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 is true and correct to the best of my knowledge and belief.

EMPLOYER (NAME OF DEPARTMENT, INSTITUTION, AGENCY, SCHOOL BOARD, ETC.)	TELEPHONE NUMBER
ADDRESS	**TITLE OF REPRESENTATIVE**
SIGNATURE OF AUTHORIZED REPRESENTATIVE	**DATE SIGNED**
X	