

**Notice of Death for Spouse or Dependent Child
(Life Insurance) Wis. Stat. § 40.70**

Minnesota Life Insurance Company - A Securian Company
P. O. Box 259708 • Madison, WI 53725-9708

MINNESOTA LIFE

Personally identifiable information, such as your Social Security number, date of birth, etc., will not be used for any purpose other than for the administration of the benefit programs administered by the Department of Employee Trust Funds.

Name of deceased (last, first, middle, previous)		Social Security number
Relationship to employee	Date of birth (mo/day/yr)	Date of death (mo/day/yr)

INSTRUCTIONS: Complete and return to your employer. Attach a certified copy of the death certificate.

CLAIM NUMBER

Employee name (last, first, middle, previous)	Date of birth (mo/day/yr)	Social Security number
Address (street, city, state, zip)		Daytime telephone number ()
Employer name or State of Wisconsin department		

At the time of death, the deceased person indicated above was my:

- Spouse. Date of marriage _____
- Dependent child. This child was unmarried and dependent upon me for at least 50% of support and maintenance, and was (check appropriate box):
 - More than 14 days of age, but under age of 19.
 - Between the ages of 19 and 25 if a full-time student (last enrolled on _____ (mm/dd/yyyy)).
 - Age 19 or older and incapable of self-support on account of physical or mental disability which can be expected to be of long-continued or indefinite duration.

If this is a claim for your dependent child, please submit your most recent federal tax return to verify their dependent status.

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.
- (3) I am a U. S. person (including a U. S. resident alien).

Employee signature X	Date (mo/day/yr)
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Basic and Spouse and Dependent group life insurance coverage was in force and premium payments were current at the time of the deceased's death. The employee has one unit or two units of Spouse and Dependent coverage. A copy of the Spouse and Dependent application is attached.

Employer representative signature X	Date (mo/day/yr)
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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.