

Waiver of Premium Claim Employer's Statement State of Georgia

Minnesota Life Insurance Company • Group Division Claims • Atlanta Branch Office
260 Peachtree Street NW, Suite 1203 • Atlanta, Georgia 30303

For Claim Information Call:
Toll Free 1 800-660-2519
Fax 404-522-1655

MINNESOTA LIFE

POLICYHOLDER'S NAME		POLICY NUMBER	BRANCH LOCATION/UNIT NUMBER
INSURED EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS			
DATE OF BIRTH (MONTH, DAY, YEAR)	DATE EMPLOYED (MONTH, DAY, YEAR)	SOCIAL SECURITY NUMBER	
JOB TITLE		DATE LAST WORKED	
STATUS ON EMPLOYMENT DATE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME If part-time, average hours per week. _____			

Amount of Coverage	Effective Date of Coverage
Employee \$ _____	_____
Spouse \$ _____	_____
Child \$ _____	_____
Other \$ _____	_____

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

NAME OF EMPLOYER	EMPLOYER'S TELEPHONE NUMBER
EMPLOYER'S ADDRESS	
AUTHORIZED SIGNATURE X	DATE