MINNESOTA LIFE

VIRGINIA RETIREMENT SYSTEM BENEFICIARY STATEMENT

Group Division Claims • Richmond Branch Office • PO Box 1193 • Richmond, VA 23218-1193 • For Claim Information Call: Toll Free **1-800-441-2258**

NAME OF EMPLOYEE (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	CLAIM NUMBER
ADDRESS (Street, City, State, Zip)		

NAME OF DECEASED (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, State, Zip)		TELEPHONE NUMBER ( )

NAME OF BENEFICIARY (Last, First, Middle Initial)	
RELATIONSHIP TO DECEASED	DATE OF BIRTH OF BENEFICIARY

CERTIFICATION - 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).

CERTIFICATION INSTRUCTIONS: You must cross out item (2) above if you have been notified by IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

Certification Notice:
THE IRS REQUIRES US TO OBTAIN CERTIFICATION OF YOUR SOCIAL SECURITY NUMBER OR TAXPAYER IDENTIFICATION NUMBER WITHOUT THIS INFORMATION, YOU MAY BE SUBJECT TO GOVERNMENT IMPOSED BACKUP WITHHOLDING FOR ANY INTEREST PAID ON THE DEATH BENEFIT.

SIGNATURE OF BENEFICIARY **X**	DATE	BENEFICIARY'S SOCIAL SECURITY NUMBER
ADDRESS OF BENEFICIARY (Street, City, State, Zip)		TELEPHONE NUMBER OF BENEFICIARY ( )

A **CERTIFIED** COPY OF THE PUBLIC DEATH RECORD IS REQUIRED AS PROOF OF DEATH

AUTHORIZATION

To all physicians and other medical professionals, the Medical Information Bureau, hospitals and other medical-care institutions and to Insurers, medical or hospital service prepaid health plans, Coroner/Medical Examiner's office, police department, employers, group policyholders, contract holders or benefit plan administrators: You are authorized to provide Minnesota Life Insurance Company, its agents, consumer reporting agencies, attorneys, and independent claim administrators acting on behalf of Minnesota Life Insurance Company with information concerning medical care, advice, treatment or supplies provided to the deceased, including information relating to mental illness, alcohol and drug dependence, and any employment-related information regarding him or her. This information will be used for the purpose of evaluating and administering claims for life and accidental death benefits.

I authorize the Company to release any information relevant to the insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom there was coverage, or to any other public or private entity as may be required. I understand that this authorization is valid for the duration of the claim. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is as valid as the original.

Date: ____________________ By: ____

Signature of next of kin or administrator of Estate. Please identify signer.

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.