

**MINNESOTA LIFE INSURANCE COMPANY**

Administrative Offices:

**Summit Administrators, Inc.**

110 West Rosamond

Houston, TX 77076-3919

Toll-Free 1.800.275.3414 • FAX 713.694.0298

**DEATH CLAIM FORM**

**PLEASE HAVE THE DECEASED INSURED'S NEXT-OF-KIN COMPLETE AND SIGN THE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**PLEASE PRINT**

INSURED'S NAME:	
CERTIFICATE NO.	INFORMANT EMAIL ADDRESS:

**ESTATE INFORMATION**

INFORMANT'S NAME:
INFORMANT'S ADDRESS:

**CREDITOR INFORMATION:**

NAME OF CREDITOR:			
ADDRESS:	CITY	STATE	ZIP
SECOND BENEFICIARY:		RELATIONSHIP	
DATE OF DEATH	FIRST PAYMENT DUE DATE		

**CALCULATIONS:**

NET PAYOFF AS OF DATE OF DEATH (PRINCIPAL & INTEREST) + *(ADD CREDIT LIFE REFUND BACK INTO PAYOFF)	\$
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**\*NO CREDIT LIFE REFUND IS DUE SINCE THE LIFE PREMIUM IS 100% EARNED AT THE DATE OF DEATH AND SHOULD NOT BE CREDITED TO THE LOAN. A CANCELLATION FOR THE UNUSED PORTION OF THE DISABILITY PREMIUM SHOULD BE SUBMITTED TO OUR OFFICE. PLEASE USE THE DATE OF DEATH AS THE CANCELLATION DATE. IF UNSURE OF THE REFUND AMOUNT, PLEASE CONTACT OUR OFFICE FOR AN ACCURATE REFUND AMOUNT.**

I HEREBY CERTIFY THAT THE INFORMATION SHOWN ABOVE IS TRUE AND CORRECT WITH RESPECT TO THE BENEFITS BEING CLAIMED HEREUNDER, AND I FURTHER CERTIFY THAT ATTACHED DEATH CERTIFICATE IDENTIFIES THIS INSURED BORROWER.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CREDITOR REPRESENTATIVE SIGNATURE

- PLEASE ATTACH:**
- 1. COPY OF DEATH CERTIFICATE**
  - 2. COPY OF THE NOTE / INSTALLMENT CONTRACT**
  - 3. COPY OF CERTIFICATE OF INSURANCE**
  - 4. COPY OF PAYOFF CALCULATIONS**