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| **Minnesota Life - Death Notification** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***\*This form is for personnel of MoDOT and MSHP ONLY, and should not be completed by any other party.\**** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Deceased Information** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | |
| Name | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| EmplID / SSN | | | | | | **/       *If the Deceased is the Dependent, provide the Dependent’s SSN.*** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Death | | | | | |  | | | | | | | | | Date of Birth | | | | | | |  | | | | | | | | | |
| Relationship to Subscriber | | | | | |  | | | | | | | | | Gender | | | | | | |  | | | | | | | | | |
| Marriage Date | | | | | | ***Complete if the Deceased is the spouse.*** | | | | | | | | | | | | | | | |  | | | | | | | | | |
| **Subscriber Information *If the Deceased was the Subscriber, skip Name /SSN/EmplID/DOB/Gender. Complete the rest of this section.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | |  | | | | | | | | | EmplID / SSN | | | | | | | **/** | | | | | | | | | |
| Date of Birth | | | | | |  | | | | | | | | | Gender | | | | | | |  | | | | | | | | | |
| Location | | | | | |  | | | | | | | | | Status | | | | | | |  | | | | | | | | | |
| Hire Date | |  | | | | | | | Last Date Worked | | | | | | | |  | | | | Retirement Date | | | | | |  | | | | |
| Home Address | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Annual Benefit Base Rate | | | | | |  | | | | | | | | | | Effective Date of ABBR | | | | | | |  | | | | | | | | |
| **Basic (State Paid) Life** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Coverage Amount | | |  | | | | | | | | | | First Effective Coverage Date | | | | | | | | | | | | |  | | | | | |
| **Beneficiary Information**\* | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | |
| *Name* | | | | *Relationship* | | | | | | | *Contact Information: Address & Phone Number* | | | | | | | | | | | | | | | | | | | | |
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| **Optional Life** | | | | | | |  | | |  | | | |  | | | | |  | | | | | | | | | | |  |  |
| Deceased Coverage Amount | | | | | | |  | | | | | | | First Effective Coverage Date | | | | | | | | | |  | | | | | | | |
| Type of Coverage | | | | | | |  | | | | | | | Current Date of Beneficiary Designation | | | | | | | | | | | | | |  | | | |
| **Beneficiary Information\*** | | | | | | | | Employee Coverage Amount***Complete if the Deceased is the spouse*** | | | | | | | | | | | | | | | | | | | | | | | |
| *Name* | | | | | *Relationship* | | | | | | | *Contact Information: Address & Phone Number* | | | | | | | | | | | | | | | | | | | |
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| **Notice Submitted to Employee Benefits by:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | | | | | | | | Date | |  | | | | | | | | | | | |
| \*Complete an additional Death Notification if more beneficiaries are designated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Instructions:*** | | |  | | | | | | | | | |  | | | | | | | | | | | | Revised: 9/5/2017 | | | | | | |
| * Complete ALL applicable fields on this form. * Pull the Basic (State paid) Life and/or the Optional Group Life Enrollment form(s) reflecting the most current beneficiary designations. * Attach the scanned form attachment(s), and this completed form in the *same* email. * Complete the Email Subject Line with “Death Notification for (Deceased’s Name)” * Send the email to: [Tawnya.Schmitz@modot.mo.gov](mailto:Tawnya.Schmitz@modot.mo.gov) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |