



PLEASE READ CAREFULLY

The application for life insurance benefits consists of the forms included in this packet, as well as the additional information noted under item 1 below. Please fill out every space on the Proof of Death form to avoid delays in our examination of your application for benefits. If a section does not apply, or information is not available, please write "NA" in the space, so that we know you did not overlook that particular question. **If an incomplete form is received, it may be returned for completion.**

Note: original documents will not be returned.

1. Include the following information with the Proof of Death form.

- Beneficiary Statement(s).
(See attached. If there is more than one beneficiary, please make a copy of the front and back of the statement.)
- Photocopy of the death certificate.
- Copies of all enrollment forms and change of beneficiary cards.
- For AD&D and Seat Belt claims, attach photocopies of newspaper clippings, police or accident reports, and any other information available regarding the accident.

2. Please have the beneficiary(ies) carefully read and complete the Beneficiary Statement which contains information about taxes.

Please make sure all required forms are completed and returned to our office. Our examination of the claim will begin when all completed forms are received. Should you have questions, our office is available to assist you. Please call 800.378.6059 or e-mail us at nylifebenefits@standard.com.

The Standard Life Insurance Company of New York

800.378.6059 Tel
PO Box 5180 Portland OR 97208

**Life Insurance Benefits
Proof of Death Claim Form**

Forms may be returned for unanswered questions.

Name of Deceased:	Effective Date of Member's Insurance:
Soc. Sec. No.:	Date of Membership/Employment:
Date of Birth:	Date Member was last actively at work:
Date of Death:	Reason Member ceased working: <input type="checkbox"/> Death <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain) _____
Name of Member <i>If Dependent Claim</i> :	Premiums paid through month of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group Policy No.:	Monthly or annual salary: \$ _____
Insurance Class (see contract):	Date of last salary increase:
Occupation of Member:	
Amount of insurance claimed:	Salary prior to increase: \$ _____
Basic Life \$ _____ Dependents Life \$ _____	Usual number of hours employee worked per week:
Additional Life \$ _____ Other (specify) \$ _____	Amount of monthly premium paid for the insured:
Accidental Death \$ _____	
Member also had the following claims with The Standard (check all that apply) <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Short Term Disability	Member was: (check all that apply) <input type="checkbox"/> Full-time <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Part-time <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried <input type="checkbox"/> Commissioned <input type="checkbox"/> Active <input type="checkbox"/> Retired

Name of Beneficiary	Relation	Date of Birth	Address	Phone

Remarks:

In addition to this form, the following items are required: (Note: original documents will not be returned)

- Beneficiary Statement.
- Photocopies of enrollment forms and any subsequent beneficiary changes.
- Photocopy death certificate.
- For AD&D and Seat Belt Claims, photocopies of newspaper clippings, police and accident reports, or other information regarding the accident.

Fraud Notice – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Acknowledgement – I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the above fraud notice.

Signature of Benefit Administrator _____	Date _____	Name of Employer or Association _____
Benefit Administrator's Name (please print) _____		Street Address _____
(_____) _____ Phone No.	City _____	State _____ Zip Code _____

Payments are sent to policyholder unless otherwise requested.

Please type or print.

AGREEMENT

I am claiming my share of the proceeds available under The Standard policy or policies listed above. I agree that this Beneficiary's Statement, a certified copy of the insured's death certificate and all other documents required by The Standard in regard to my claim shall serve as proof of death of the insured. I also agree that, by providing this form, The Standard does not waive any of its rights or defenses in regard to the payment of my claim.

IMPORTANT TAX INFORMATION

Under the Federal Income tax law, we are **required** to request that you (*as payee*) provide The Standard (*as payor*) with your correct Social Security number or Taxpayer Identification number.

Certification – Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (*or I am waiting for a number to be issued to me*), **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.

Certification Instructions — Check here if you are subject to backup withholding

Fraud Notice – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Acknowledgement – I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the above fraud notice.

_____ <i>Signature of Beneficiary (please use dark ink and sign as you would a check)</i>	_____ <i>Relationship to Deceased</i>		
_____ <i>Please Print Name</i>	_____ <i>Date of Birth</i>		
_____ <i>Beneficiary's Social Security No./Taxpayer ID No. (required)</i>			
_____ <i>Address</i>	_____ <i>City</i>	_____ <i>State</i>	_____ <i>Zip Code</i>
(_____)_____ <i>Work Phone No.</i>	(_____)_____ <i>Home Phone No.</i>		

Policyholder Use Only

Name of Deceased: _____

Group Policy No.: _____