



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.**

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.)
- Certified death certificate.
- All original enrollment forms and change of beneficiary cards.
- For AD&D and Seat Belt claims, attach 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.

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 last actively at work:	
Date of Death:			Reason Member did not return to work: <input type="checkbox"/> Death <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain) _____	
Name of Member <i>If Dependent Claim</i> :			Last month premium was paid for Member or Dependent:	
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 \$ _____				
Additional Life \$ _____ Other (specify) \$ _____			Usual number of hours employee worked per week:	
Accidental Death \$ _____			Amount of monthly premium paid for the insured:	
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:				
<p>In addition to this form, the following items are required.</p> <ul style="list-style-type: none"> ● Beneficiary Statement. ● Original enrollment forms and any subsequent beneficiary changes. ● Certified death certificate. ● For AD&D and Seat Belt claims, newspaper clippings, police and accident reports, or other information regarding the accident. <p>Acknowledgement</p> <p>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.</p>				
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.				

