TheStandard®

Standard Insurance Company
Life Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

Life Insurance Benefits Application Instructions

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 "NONE" in the space, so that we know you did not overlook the 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 and the Standard Secure Access account.

Beneficiaries may receive their funds via Standard Secure Access (SSA) in accordance with the terms of the group policy. SSA is a convenient, interest-bearing checking account in which life insurance proceeds are deposited. With SSA, the beneficiary is able to earn a competitive rate of interest on the life insurance proceeds while taking the time to weigh important financial decisions that often follow the death of a loved one.

The Beneficiary will be mailed a checkbook once the claim is approved. In addition, all SSA accountholders have access to 24-hour customer service via a voice response unit (VRU) and a dedicated customer service team.

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 **800.628.8600** or e-mail us at **lifebenefits@standard.com.**

Reset

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Life Insurance Benefits
Proof of Death Claim Form

Please type or print. Form may be returned for unanswered questions.

Name of Deceased	Effective Date of Member's Insurance
Social Security No.	Date of Membership/Employment
Date of Birth	Date member was last actively at work / Had employment terminated prior to death? ☐ Yes ☐ No Date: _____
Date of Death	Reason member ceased working: ☐ Death ☐ Illness ☐ Other *(explain)* _____
If Dependent Claim, Name of Member	Last month premium was paid for member or dependent
Group Policy No. / Insurance Class *(see contract)*	Monthly or annual salary $
Occupation	Date of last salary increase
Amount of insurance claimed: Basic Life $ _____ Dependents Life $ _____ Additional Life $ _____ Other *(specify)* $ _____ Accidental Death $ _____	Salary prior to increase: $ / Usual number of hours employee worked per week / Amount of monthly premium paid for the insured
Member also had the following claims with Standard Insurance Company: ***(check all that apply)*** ☐ Long Term Disability ☐ Short Term Disability ☐ Waiver of Premium	Member was: ***(check all that apply)*** ☐ Full-time ☐ Part-time ☐ Commissioned ☐ Union ☐ Non-Union ☐ Active ☐ Hourly ☐ Salaried ☐ Retired

Name of Beneficiary	Social Security No.	Relation	Date of Birth	Address*	Phone

***If the mailing address is a PO Box, we must have a street address in addition to the PO Box mailing address.**

Remarks:

In addition to this form, the following items are required

- 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.

Acknowledgment

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 fraud notice on page 3 of this form.

Signature of Benefit Administrator **Date**

Name of Employer or Association

Benefit Administrator's Name ***(Please print)***

Street Address

(_____) _____
Phone No.

City State ZIP

Payments paid via SSA will be sent directly to beneficiary, payments paid via check will be sent to policyholder, unless requested otherwise.

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Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

MARYLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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 subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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Life Insurance Benefits Beneficiary Statement

Tax Information

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

Please read and complete the following information in order to comply with Federal Income Tax law.

Certification — Under Penalties Of Perjury, I Certify That:

1. The number shown on this form is my correct Social Security/Taxpayer Identification Number *(or I am waiting for a number to be issued to me)*, **and**
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) 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 (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions — You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

Method Of Payment —

Standard Secure Access

Beneficiaries may receive their funds via Standard Secure Access (SSA) in accordance with the terms of the group policy. SSA is a convenient, interest-bearing checking account in which life insurance proceeds are deposited. With SSA, you are able to earn a competitive rate of interest on the life insurance proceeds while taking the time to weigh important financial decisions that often follow the death of a loved one.

The Beneficiary will be mailed a checkbook, once the claim is approved. In addition, all SSA accountholders have access to 24-hour customer service via a voice response unit (VRU) and a dedicated customer service team.

If you decide to assign a portion of your benefits to a funeral home, please include a notarized assignment form *(supplied by the funeral home)* and an itemized copy of the funeral bill. A separate check for the amount of the assignment will be delivered directly to the funeral home.

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 fraud notice on page 5 of this form.

Signature of Beneficiary ***(please use dark ink and sign as you would a check)*** | Relationship to Deceased

Name *(please print)* | Date of Birth

Social Security Number *(required)*

Mailing Address ***(if this is a PO Box, a street address is required)*** | City | State | ZIP

Street Address ***(only if your mailing address is a PO Box)*** | City | State | ZIP

Work Phone No. | Home Phone No.

This Portion For Use By Standard Insurance Company Only

Claim No.(s) _____ Policy No.(s) _____

Deposit Amount $ _____ Division 037 Sub 107

Code 402 ☐ 403 ☐ 404 ☐ 405 ☐ 406 ☐ 407 ☐ ☐ M ☐ F

Transmittal Date | Authorized Signature

Policyholder Use Only

Name of Deceased: _____

Group Policy No.: _____

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