

Combined Insurance Worksite Solutions
A unit of Combined Life Insurance Company of New York
 Claim Department • PO Box 6700 • Scranton, PA 18505-0700 Telephone 1-888-441-7936 Fax 312-351-6930

Beneficiary Statement for Life Insurance

Claim Number: _____

TO BE COMPLETED BY BENEFICIARY

DECEDENT INFORMATION

Deceased's Full Name				Policy Number	Form/Plan Number					
Please list other names the deceased may have used such as maiden name, nickname, hyphenated name, alias, etc.				Policy Number	Form/Plan Number					
Deceased's Address (Street and No.)		City	State	Zip	Policy Number	Form/Plan Number				
Deceased's Date of Birth:	Mo.	Day	Year	Deceased's Date of Death:	Mo.	Day	Year	Policy Number	Form/Plan Number	
	/	/			/	/				
<i>If death was due to SICKNESS Please complete</i>		Nature of sickness								
<i>If death was due to ACCIDENT Please complete</i>		Date of accident		Nature of injuries						
		Mo.	Day	Year						
		/	/		Please describe where and how accident occurred					

BENEFICIARY INFORMATION

Beneficiary's full name				Beneficiary's Birth Date:	Mo.	Day	Year	Relationship to deceased
					/	/		
Mailing Address (Street and No.)			City	State	Zip	Home telephone # ()		
If beneficiary is a minor please list parent/guardian name and address							Work telephone # ()	
E-Mail Address							Cell telephone # ()	

FRAUD NOTIFICATION

NEW YORK: 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.

Beneficiary's Signature

Date

REQUIRED SIGNATURE OF BENEFICIARY AND W-9 CERTIFICATION

By making claim to these proceeds, I declare that all the answers recorded on this Beneficiary's Statement are true and complete to the best of my knowledge and belief. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

Substitute W-9

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 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, and
3. I am a U.S. person (including U.S. resident alien).

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Beneficiary's Signature

Date

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Social Security / Tax ID Number

Printed Name of Beneficiary

Relationship*

*If I signed on behalf of the beneficiary as the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

Please send the following documents to us by mail, or fax them to us at 1-312-351-6930.

1. Claim Form (fully completed and signed)
2. A certified copy of the Death Certificate
3. A copy of the obituary notice, if available