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

If death was due to SICKNESS Please complete	Nature of sickness	
If death was due to ACCIDENT Please complete	Date of accident Mo. Day Year / /	Nature of injuries
	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** | **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