TheStandard®

Standard Insurance Company
Life Benefits Department
800.628.8600 Fax 888.414.0389 Lifebenefits@standard.com
PO Box 2800 Portland OR 97208

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.**

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 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 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 email us at **lifebenefits@standard.com.**

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Reset

Life Insurance Benefits Proof of Death Claim Form

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

Name of Deceased:	Effective Date of Member's Insurance:
Social Security No.:	Date of Membership/Employment:
Date of Death: / Date of Birth:	Date Member was last actively at work:
CLAIM TYPE: ☐ Member ☐ Spouse ☐ Child	Had Member's employment terminated prior to death? ☐ Yes ☐ No If Yes, Date: _____
Name of Member:	Reason Member ceased working: ☐ Death ☐ Illness ☐ Other *(explain)* _____
Group Policy No.: **168759** / Insurance Class: *(see Group Policy)*	Premiums paid through month of death? ☐ Yes ☐ No If No, Date: _____
Occupation:	Monthly or annual salary: $ / Date of last salary increase:
Does Age Reduction apply? ☐ Yes ☐ No	Salary prior to increase: $ / Date of prior salary increase:
Amount of Insurance Claimed: (Please apply Age Reduction if applicable) Basic Life $ _____ Additional Life $ _____ Dependents Life $ _____ Other (specify) $ _____ Accidental Death $_____ If Accidental Death, please provide: ☐ Authorization Form ☐ Police Incident Report (if applicable) ☐ Autopsy/Toxicology (if applicable)	Usual number of hours worked per week: Amount of monthly premium paid for the insured: $ Member was: *(check all that apply)* ☐ Full-time ☐ Union ☐ Hourly ☐ Part-time ☐ Non-Union ☐ Salaried ☐ Commissioned ☐ Active ☐ Retired
Member also had the following claims with Standard Insurance Company: *(check all that apply)* ☐ Long Term Disability ☐ Short Term Disability ☐ Waiver Of Premium	

Name of Beneficiary	Social Security No.	Relationship	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, please submit the following items to avoid claim delays: (Note: original documents will not be returned)

- Beneficiary Statement.
- Photocopies of enrollment forms and any subsequent beneficiary changes.
- If no beneficiary information on file, please note in remarks box.
- Photocopy of death certificate.
- For Accidental Death claims, if reports are not available when a claim is submitted, The Standard will attempt to order reports directly. Please have the family complete the authorization form. This form can be located in AdminEase or by contacting The Standard directly.
- If annual earnings include commissions or bonuses, please include supporting documentation.

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 3 of this form.

_____
Signature of Benefit Administrator Date

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

(_____) _____
Phone No.

_____
Email

Harmony Public Schools
Name of Employer or Association

_____
Street Address

_____
City State Zip Code

Payments will be sent directly to the beneficiary unless requested otherwise.

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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

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.

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.