NATIONAL BENEFIT LIFE
INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800-222-2062

CLAIM INSTRUCTIONS

Please review these instructions as you complete the enclosed Claimant Statement. If you need any assistance, please call us, toll-free at (800) 221-2554.

- All sections of the Claimant's Statement must be filled out completely by the Claimant (the beneficiary). The Claimant must sign the bottom of the form and the signature must be notarized. If there is more than one Claimant, each beneficiary must complete a separate form.

- When the beneficiary is a minor, incapacitated, or is unable to sign, the person empowered to act for the beneficiary must sign the Claimant's Statement. (Supporting documents; i.e., Power of Attorney, Certified Letter of Guardianship of the beneficiary's estate or Conservatorship Appointed must be attached to the Claimant's Statement). The Claimant's Statement must include the Social Security number of the minor child or incapacitated beneficiary.

- If the Claimant is the executor or administrator of the estate of the insured or the trustee for a beneficiary, such person must complete the Claimant's Statement. Certified Letters Testamentary, Letter of Administration or Trust Document must be attached. The tax identification number of estate or trust is required.

- The certified death certificate must display the colored emblem or raised seal of the issuing authority. If any Primary beneficiary named in the policy has died before the insured, a certified death certificate of the beneficiary must be attached.

- All documents sent to us, including but not limited to the certified death certificate, become a part of the claim file and cannot be returned to you.

Payment Methods and Options for Claim Proceeds:

You may choose to receive one check for the entire amount of the proceeds.

For payments under $2,500, a check will be issued.

For payments of $2,500 or more you may choose one of the settlement options described in the policy, unless the policy specifies a different amount. The policy may include settlement options which provide fixed interest rates ranging from 2% to 3.5%. Please refer to the policy contract and review all the settlement options that may be available to you.

Important Reminders

- Each section of the Claimant's Statement must be completed.
- The Claimant's Statement must be signed and notarized.
- Provide additional required documentation (e.g. letters testamentary, trust documents, letters of administration).
- Provide a certified Death Certificate

NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800-222-2062

For assistance, please call Customer Service at 800-221-2554

CLAIMANT'S STATEMENT

Please Attach a Certified Death Certificate

Please show all names the deceased was known by, including full name, maiden name, hyphenated name, nickname, derivative form of first and/or middle name, or any alias.

1. Deceased's Name in Full:

____

____

____

2. Policy Numbers: ______________________________

3. Deceased's Birth Date: ______________________ Source from which Birth Date Obtained: ______________________
Birth Certificate, Family Record, Other Record

4. Residence of Deceased at Death: ______________________________
Street Address City State ZIP

5. Date of Death: ______________________ Place of Death: ______________________

6. Cause of Death______________________ 7. Your relationship to the Deceased: ______________________

8. Employer of Deceased ______________________ Deceased's Occupation: ______________________

9. Is claim being made for Accidental Death Benefits? Yes ☐ No ☐

10. If deceased has insurance with other companies, list names of companies and amounts below:

Names of Companies	Amounts

11. Marital Status of Deceased: ______________________ Spouse's Name: ______________________

Children of Deceased______________________ Spouse's Address: ______________________

______________________ ______________________

The furnishing of this form or its acceptance by the Company must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

The Claimant Information on the next page *must* be filled out completely in order to avoid any delay.

DCL10 01/20NY

CLAIMANT INFORMATION

The information in this section pertains to the Claimant (the beneficiary)
***Please read carefully*. Please print or type and complete in full. This form must be signed and notarized.**

1. Claimant's Full Name: ____

2. Date of Birth: ______________________________ Social Security No. or Tax ID: __________________________
· Individual – Claimant's Social Security Number ·Estate Tax ID Number
· Guardian – Child's Social Security Number ·Trust Tax ID Number

3. Permanent Address: ____
Number, Street and Apt. or Suite No. (do not use a P.O. or in-care-of address)

____
City State Zip Code

4. Mailing Address: ____
(if different from above) Number, Street and Apt. or Suite No.

____
City State Zip Code

5. Home Phone: (_____)_____________Work Phone: (_____)_____________Cell Phone: (_____)_________________

Please select your method of payment by marking the appropriate box below:

☐ Check ☐ Settlement Option # _____________ (refer to the policy and Claim instructions)

Please be sure to review the payment method information found in the Claim Instructions on page 1.

Under the penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number; 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 failure to report interest or dividends, or (c) that the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. person (including a U.S. resident alien).

Certification Instructions:

- You must cross out item 2 if the IRS has notified you that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The following statement is made in accordance with Insurance Laws:

Any person who knowingly and with intent to defraud any insurance company or other person files an application of 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 violation.

Signature of Claimant: X____
(See "Important Reminders" on Page 1, "Claim Instructions")

Subscribed and sworn to before me this ____________________Day of ________________________, 20__________

Signature of Notary Public: X____

PHYSICIAN'S STATEMENT

If death occurred within two years of the policy issue date, or if Accidental Death Benefits are claimed, please complete the Authorization on page 6 and have the Deceased's physician complete the Physician's Statement below and return to the Company.

Full name of the deceased: Residence at death: Age at death or date of birth:	Date of death: Place of Death: (If Hospital or Institution, give name)

Cause of death (Enter only one cause for each of a, b, and c.) Disease or condition directly leading to death: (This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury or complication that caused death.) (a) Antecedent causes. (Morbid conditions, if any giving rise to the above cause (a) stating the underlying cause last.) Due to (b) Due to (c) Other significant conditions: (Contributing to the death but not related to the disease or condition causing death.)	Interval between onset and death: (a) (b) (c)

Date of First Attendance in Last Illness:	Date of Last Attendance in Last Illness:
If Death was due to accident, suicide or homicide, specify which. Describe briefly.	Was an inquest held? ☐ Yes ☐ No Was an autopsy performed? ☐ Yes ☐ No If so, by whom and with what findings?

Have you treated or advised the deceased during the last 5 years, prior to last illness? ☐ Yes ☐ No

Did the deceased, to your knowledge, receive treatment during the last 5 years from any other physician or in any Hospital or Institution? ☐ Yes ☐ No

If Yes to either question, please furnish the following:

Name	Address	Nature of Illness or Injury	Dates

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF:

_______________________________________ M.D. _______________________________________
Physician's Signature Print Signing Physicians Name

____
Street Address

____
City State Zip Code

(_________)______________________________ ______________________________
Area Code Phone Number Date

NATIONAL BENEFIT LIFE INSURANCE COMPANY
30-30 47th Avenue, Suite 625, Long Island City, NY 11101-3433 • 800-222-2062

Authorization

***IMPORTANT:** To avoid delay, please sign authorization below.*

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

By my signature below: (1) I authorize National Benefit Life Insurance Company, its affiliates, reinsurers, and authorized representatives, including agents, insurance support organizations and service providers to receive all health information on the deceased individual named below; (2) I acknowledge that health information may include any and all individually identifiable health information within the past 20 years, including medical records, reports, prescription histories, diagnostic testing, and lab work on the diagnosis, treatment, and prognosis of any physical or mental condition and the use of drugs or alcohol, autopsy and toxicology reports, any employment or wage or financial information, phone call records, information about driving records (MVR), and information with respect to other insurance coverage or claims of the insured or family members for which claim is being made; (3) I authorize any licensed physician, medical practitioner, hospital, clinic, Medical Examiner, Coroner, or other medical care institution or medical related facility, pharmacy, pharmacy benefit manager, employer, insurance or reinsurance company, group policyholder, governmental or law enforcement agencies, Social Security Administration, the Veterans Administration, and the Department of Motor Vehicles, Kaiser Permanente, or other entity or person to disclose all health information on the deceased individual named below; (4) I understand that the information released under this Authorization will be used for the purposes of evaluating and administering a claim for benefits; (5) I acknowledge that this Authorization expires thirty (30) months from the date is it signed; (6) I understand that I can revoke this authorization at any time by giving written notice to the Insurance Company named above at the address shown above. I also understand that my revocation will not apply retroactively or prevent the Company from contesting a claim for insurance benefits; (7) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure claim review; however, the Company may not be able to make any benefit payments; (8) I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality; and (9) I agree that a photographic copy of this Authorization shall be as valid as the original and I may receive a copy of this Authorization after it is signed.

Signed this ____________________________day of ______________________________, 20___________

X____ ____
Signature of Next of Kin Relationship to Insured

Address: ____

____
City State Zip Code

Phone Number: (_____)__________________________

____ ____
Print Name of Deceased Insured Deceased Insured's Date of Birth

____
Deceased Insured's Social Security Number