



Death Benefit Claim Filing Instructions

TO HELP AVOID DELAY, PLEASE READ THESE INSTRUCTIONS CAREFULLY AND ANSWER ALL QUESTIONS FULLY.

- Submit a CERTIFIED copy of Official Death Certificate of deceased insured/annuitant; we cannot accept a photocopy.
- Submit a CERTIFIED copy of Official Death Certificate of each deceased beneficiary.
- Submit completed CLAIM FOR DEATH BENEFIT. **Each surviving beneficiary must make claim and sign as claimant on Page 4. A copy of Page 4 should be made for each surviving beneficiary. Then each beneficiary should complete ALL PARTS on Page 4. If there are no surviving beneficiaries, see Page 5.**
- Submit the Benefit Certificate(s) (policy(ies)) of the deceased insured/annuitant. **If the benefit certificate(s) has(have) been lost or destroyed, please check the AFFIDAVIT OF LOST CERTIFICATE box on Page 4.**
- Complete Page 5 only if all named primary and contingent beneficiaries predeceased the insured/annuitant. See instructions on Page 5.
- If any claimant is a **minor** (under the age of 18), please furnish a certified copy of the court authorized Appointment of Guardianship. Party(ies) designated as guardian(s) must sign as claimant(s). If guardianship has not been granted, please contact our office for further instructions.
- If any claimant has designated an **attorney-in-fact** pursuant to a Power of Attorney, please furnish a copy of the Power of Attorney appointment(s). The attorney(s)-in-fact must sign as claimant(s).

RETURN TO:

WOMAN'S LIFE INSURANCE SOCIETY
1338 MILITARY STREET
PO BOX 5020
PORT HURON MI 48061-5020

PRIVACY:

As a consumer, you may request a privacy notice from *Woman's Life Insurance Society* that describes its policies and practices concerning nonpublic personal information about yourself. You may do so by calling the Society at 1-800-521-9292.

If you prefer that *Woman's Life Insurance Society* not disclose nonpublic financial information about you to nonaffiliated third parties, you may opt out of those disclosures by directing us not to make those disclosures (other than permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, please call the Society at 1-800-521-9292.

Woman's Life Insurance Society® A Fraternal Benefit Society
1338 Military Street PO Box 5020 Port Huron Michigan 48061-5020
800.521.9292 810.985.5191 www.womanslife.org



Claim for Death Benefit

Claim Number	Certificate Number(s)
--------------	-----------------------

In furnishing this or other claim forms for the convenience of the claimant, the Society does not admit any liability or waive any of its rights.

INFORMATION ABOUT THE DECEASED (please print or type)

First Name	Middle Initial	Last Name
------------	----------------	-----------

Any other name by which deceased was known (such as maiden name, hyphenated name, nickname, derivative form of first and/or middle name or alias)

Street Address

City	State	Zip
------	-------	-----

Date of Deceased's Birth	Place of Birth
--------------------------	----------------

Date of Deceased's Death	Place of Death
--------------------------	----------------

Cause of Death

Was death the result of suicide? Yes No

Was death the result of accident? Yes No

If the certificate contains an accidental death benefit and claim is being made for it, please furnish a detailed police report, coroner's report and newspaper clippings. We may require other information depending on the circumstances of death.

Fraud Warning Notices

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE.

ARIZONA – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

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

COLORADO – **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 a 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.**

DELAWARE – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

IDAHO – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA – Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY – Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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

MAINE, TENNESSEE, VIRGINIA & WASHINGTON – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND – 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.

MINNESOTA – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE – Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

Continued on next page.

NEW MEXICO - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES.

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.

OHIO - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA - WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of an felony.

OREGON - Any person who, with an intent to knowingly defraud, files a claim containing materially false information MAY BE guilty of insurance fraud.

PENNSYLVANIA - 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.

TEXAS - 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.

ALL OTHER STATES - 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 act, which is a crime and subjects such person to criminal and civil penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

ALL PARTS MUST BE COMPLETED BY CLAIMANT.
Please make a duplicate copy, if needed, for additional claimants to complete.

AUTHORIZATION

To: The Medical Information Bureau, insurance companies, physicians, surgeons, dentists, chiropractors, pathologists, medical examiners, chiropodists, optometrists, psychologists, psychiatric social workers, physical therapists, occupational therapists, paramedicals, nurses, hospitals, clinics, sanitariums, outpatient centers, related health care professionals, related institutions, employers.

I hereby authorize and ask you to give to *Woman's Life Insurance Society* all the medical information that you have about (name of deceased insured/annuitant) _____. This includes all past medical history. It is to include all symptoms, diagnosis and treatments and reports. It includes all information pertaining to drug or alcoholism treatment; all information regarding AIDS or AIDS related conditions or the presence of antibodies to the AIDS virus; as well as the following items:

Health information, past treatments, medical advice, symptoms, diagnosis, opinions, present treatments, examination results, X-ray results, autopsy reports, medical examiner's findings, biopsy results, biological-chemical tests, related medical facts.

I further understand that this information will be used by *Woman's Life Insurance Society* and its reinsurers to help them evaluate this claim for death benefits. This form will only be good for the duration of this claim. As to alcohol and drug information covered by federal regulations, this form may be revoked at any time by notice to *Woman's Life Insurance Society*; but any actions taken before such notice is received by *Woman's Life Insurance Society* will be valid. I know that I have the right to have a copy of this form. I also know that anyone authorized to act on my behalf also has a right to have a copy. A photocopy or facsimile of this form has the same force as the original one.

Signed below this _____ day of _____, 20_____.

FEDERAL LAW REQUIRES THIS INFORMATION: We may be required to withhold, and send to the IRS on your behalf, 28% of certain reportable payments you may be entitled to, unless we have your correct social security number and you state that you have not been notified that you are subject to an IRS Back-up Withholding Order or have been notified that you are no longer subject to an IRS Back-up Withholding Order on interest and dividends.

Under penalty of perjury, I certify that:

1. The social security number provided below is my correct social security number and
2. **Please check one:**
 - I have not been notified by the IRS that I am subject to a Back-up Withholding Order on interest and dividends.
 - I have been notified by the IRS that I am subject to a Back-up Withholding Order on interest and dividends.
 - The IRS has notified me that I am no longer subject to a Back-up Withholding Order on interest and dividends.

AFFIDAVIT OF LOST CERTIFICATE

If the benefit certificate(s) has(have) been lost or destroyed, please check the box below:

I hereby certify certificate number(s) _____ has(have) been lost or destroyed and has(have) not been delivered to any person or business enterprise for any right, title, or interest in it(them). If at any time said certificate(s) should be found, I shall immediately forward it(them) to the National Secretary-Treasurer of *Woman's Life Insurance Society*.

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. By signing below, you agree under penalties of perjury that the information in this claim form is complete and true to the best of your knowledge. Refer to "**Fraud Warning Notices**" for your state.

Printed Name of Claimant		Signature of Claimant		
Street Address				
City		State	Zip	
Daytime Phone Number		Fax # or E-mail Address		Date
Date of Birth	Relationship to Insured/Annuitant		Social Security Number	

COMPLETE THIS PAGE ONLY IF ALL NAMED PRIMARY AND CONTINGENT BENEFICIARIES PREDECEASED THE INSURED/ANNUITANT.

This form must be completed and signed at the bottom by a *disinterested person*, someone who has no monetary interest in the claim.

If there is a surviving spouse of the deceased insured/annuitant, only questions 1 through 3 must be completed and the **surviving spouse** must sign as claimant on Page 4.

If no spouse survived the deceased insured/annuitant, only questions 1 through 7 must be completed and each **surviving child** must sign as claimant on a copy of Page 4.

If no spouse or child survived the deceased insured/annuitant, only questions 1 through 8 must be completed and each **surviving parent** must sign as claimant on a copy of Page 4.

If no spouse, child, or parent survived the deceased insured/annuitant, all questions must be completed and each **surviving grandchild** must sign as claimant(s) on a copy of Page 4.

If none of the foregoing survived the deceased insured/annuitant, all questions must be completed and the **Administrator or Executor** of the deceased insured/annuitant's Estate must furnish a certified copy of appointment and must sign as claimant on Page 4.

1. Was the deceased insured/annuitant ever married? Yes No

2. Was deceased insured/annuitant married and was spouse living at the time of death? Yes No

3. Last spouse of deceased insured/annuitant:
 Name _____
 Date of Death (if applicable) _____ Date of Divorce (if applicable) _____
 Residence, if living, or else place of death or divorce _____

4. How many children both living and dead did deceased insured/annuitant have? _____

5. Did deceased insured/annuitant ever legally adopt anyone? Yes, provide proof. No

6. How many children died prior to date of death of deceased insured/annuitant? _____

7. Children of deceased insured/annuitant including legally adopted children: (Attach supplemental sheet if necessary)

<u>Name</u>	<u>Date of Birth</u>	<u>Date of Death</u>	<u>Residence, if living, or else place of death</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Mother and Father of deceased insured/annuitant:

<u>Name</u>	<u>Date of Birth</u>	<u>Date of Death</u>	<u>Residence, if living, or else place of death</u>
_____	_____	_____	_____
_____	_____	_____	_____

9. How many grandchildren both living and dead did deceased insured/annuitant have? _____

10. How many grandchildren died prior to death of deceased insured/annuitant? _____

11. Grandchildren of deceased insured/annuitant: (Attach supplemental sheet if necessary)

<u>Name</u>	<u>Date of Birth</u>	<u>Date of Death</u>	<u>Residence, if living, or else place of death</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Printed Name of <i>Disinterested Person</i>	Signature of <i>Disinterested Person</i>
--	---

Street Address _____

City _____	State _____	Zip _____
------------	-------------	-----------

Date Signed _____	Daytime Phone Number _____
-------------------	----------------------------