agility
Easy Online Benefits From The Standard

Standard Insurance Company
PO Box 2910 Portland OR 97208 855.737.4575 Tel

Life Insurance Benefits Application Instructions

Our Commitment

We are here to assist you and, most importantly, we provide employees and their families the caring and responsive service they deserve.

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.

Questions

Should you have any questions regarding the forms or claim process, please contact the eBenefits Claims Administration team at **855.737.4575** or via email at **ebenefits@standard.com**.

Contact Information

P.O. Box 2910
Portland, OR 97208
Tel: 855.737.4575
Fax: 855.737.4576

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Reset

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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 Birth:	Date member was last actively at work: / Had employment terminated prior to death? ☐ Yes ☐ No Date:_____
Date of Death:	Reason member ceased working: ☐ Death ☐ Illness ☐ Other *(explain)* _____
If Dependent Claim, Name of Member:	Premiums paid through month of death? ☐ Yes ☐ No
Group Policy No.: / Insurance Class *(see contract)*	Monthly or annual salary: $
Occupation:	Date of last salary increase:
Amount of insurance claimed: Basic Life $_____ Dependents Life $_____ Additional Life $_____ Other *(specify)* $_____ Accidental Death $_____	Salary prior to increase: $ / Usual number of hours employee worked per week: / Amount of monthly premium paid for the insured:
Member also had the following claims with Standard Insurance Company: *(check all that apply)* ☐ Long Term Disability ☐ Short Term Disability ☐ Waiver of Premium	Member was: *(check all that apply)* ☐ Full-time ☐ Part-time ☐ Commissioned ☐ Union ☐ Non-Union ☐ Active ☐ Hourly ☐ Salaried ☐ Retired

Name of Beneficiary	Social Security No.	Relation	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, the following items are required:

- Beneficiary Statement.
- Photocopies of enrollment forms and any subsequent beneficiary changes.
- Photocopy death certificate.
- For AD&D and Seat Belt Claims, photocopies of newspaper clippings, police and accident reports, or other information regarding the accident.

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

Name of Employer or Association

Benefit Administrator's Name *(Please print)*

Street Address

(_____)_____
Phone No.

City State Zip Code

Payments paid via check will be sent to policyholder, 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.

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Life Insurance Benefits
Beneficiary Statement

Tax Information

Under the Federal Income Tax law, we are required to request that you *(as the payee)* provide Standard Insurance Company *(as payor)* with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with Federal Income Tax law.

Certification — Under Penalties Of Perjury, I Certify That:

1. The number shown on this form is my correct Social Security/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.

Certification Instructions — Check here if you are subject to backup withholding ☐

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 5 of this form.

Signature of Beneficiary *(please use dark ink and sign as you would a check)*

Relationship to Deceased

Name *(please print)*

Date of Birth

Beneficiary's Social Security No./Taxpayer ID No. *(required)*

Mailing Address *(if this is a PO Box, a street address is required)*

City State Zip Code

Street Address *(only if your mailing address is a PO Box)*

City State Zip Code

Work Phone No.

Home Phone No.

Policyholder Use Only

Name of Deceased: _____

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