SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.sm1ny.com

THIS DOCUMENT IS FORM FILLABLE

Clear Form

Individual Life Insurance Contestable Death Claim Form
Instructions and Additional Information

- **Who must complete the Individual Life Insurance Contestable Death Claim forms?** The forms must be completed by each person or entity named as beneficiary. If the beneficiary is a minor, incompetent, or an estate, a certified copy of the legal appointment of the personal representative must be furnished. Each beneficiary must complete an Individual Life Insurance Contestable Death Claim Form.

- **How does a corporation or other business entity, or a trust sign the form?** If the beneficiary is a corporation or other business, the legal name of the corporation or business entity must be followed by the signature and title of the officer authorized to sign for the corporation or business entity. A copy of the corporate resolution indicating who is authorized to act on behalf of the company should be submitted with the completed claim form. If the beneficiary is a trust, the legal name of the trust and trust date must be followed by the name of the trustee(s) and trustee(s) signature. Include the title of "Trustee" following each signature. A copy of Trust should be submitted with the completed claim form.

- **What if the Beneficiary Designation does not list specific names of the children?** When any death proceeds are payable to unnamed children an affidavit must be completed furnishing the given names, addresses, social security numbers and dates of birth of each child.

- **Can the Death Proceeds be sent to the funeral home?** When the death proceeds are to be assigned to a funeral home, the original assignment specifying the amount to be assigned to the funeral home and a copy of the itemized bill should be submitted with the completed claim form.

- **Do I have to complete the entire form?** In order to ensure prompt handling of your claim, please complete the form in its entirety.

- **Where do I send my completed form and documentation?** Mail your completed form and documentation to Security Mutual Life Insurance Company of New York:

  Regular Mail:
  Individual Claims
  PO Box 1625
  Binghamton, NY 13902-1625

  Overnight Delivery/Certified Mail:
  Individual Claims
  100 Court Street
  Binghamton, NY 13901

- **Are there any Settlement Options or other methods for paying out the Benefit available other than a Lump Sum Payment?** Please refer to the settlement option page, from the policy, for options available to you. In the Settlement Option section of the form, indicate the quotes you would like to receive, if any. If you have any questions about which settlement options are available, please call our Home Office at 1-800-846-6305.

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Individual Life Insurance Contestable Death Claim Form

Insured Information

Name of Deceased Insured: _____ Social Security Number: _____

Policy Number(s): _____ , _____ , _____ , _____

Date of Death:_____Place of Death:_____ Date of Birth: _____

Cause of Death, if known: _____

Marital Status: ❑ Single ❑ Married ❑ Widow/Widower ❑ Separated ❑ Divorced ❑ Civil Union/Domestic Partner

Address: _____
Number Street name Apt/Box # (if any)

_____
City State Zip Code

Please list any and all other names by which the Insured may have been known: _____

_____

If the deceased is:

Applicant/Insured: Name and address of Employer at time of application

Name: _____

_____
Number Street Apt/Box No. (if any)

_____
City State Zip Code

Spouse: Name and address of Employer at time of application

Name: _____

_____
Number Street Apt/Box No. (if any)

_____
City State Zip Code

Dependent Child: Name and address of School being attended at time of application

Name: _____

_____
Number Street Apt/Box No. (if any)

_____
City State Zip Code

Beneficiary Information

Name: _____

Address: _____
Number Street name Apt/Box # (if any)

_____
City State Zip Code

Relationship to Insured: ☐ Spouse ☐ Ex-Spouse ☐ Child ☐ Parent ☐ Other If other, please Explain: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Daytime Phone Number: (_____) _____ Evening Phone Number: (_____) _____

Cell Phone Number: (_____)_____

E-mail Address: _____ Fax Number: _____

Please return all policies for which you are filing a claim. If a policy cannot be returned, please indicate by checking the Lost Policy Certification box below and filling in missing Policy numbers.

Lost Policy Certification

☐ The undersigned Beneficiary hereby certifies that to the best of his or her knowledge:

Policy Number(s): _____, _____ ,_____, _____ has(have) been lost or destroyed, and is (are) not in the possession, custody or control of any person, corporation or other entity; and that neither this (these) Policy(s) nor any interest therein has been assigned or in any way transferred or encumbered.

Medical History

Please provide the names and addresses of all doctors and hospitals where the deceased was seen within the 7 years prior to the date of death. If additional space is needed, please attach a separate paper. Please print legibly.

Doctor full name:_____ Phone Number: _____

Address: _____
Number Street City State Zip Code

Dates Seen: _____ Reason Seen: _____

Dates Seen: _____ Reason Seen: _____

Doctor full name:_____ Phone Number: _____

Address: _____
Number Street City State Zip Code

Dates Seen: _____ Reason Seen: _____

Dates Seen: _____ Reason Seen: _____

Hospital full name: _____ Phone Number: _____

Address: _____
Number Street City State Zip Code

Dates Seen: _____ Reason Seen: _____

Dates Seen: _____ Reason Seen: _____

Hospital full name: _____ Phone Number: _____

Address: _____
Number Street City State Zip Code

Dates Seen: _____ Reason Seen: _____

Dates Seen: _____ Reason Seen: _____

Pharmacy Information

Please provide the name and address of the deceased's primary pharmacy.

Pharmacy Name: _____

Address: _____
Number Street City State Zip Code

Health Insurance Carrier

Please provide the name and address of the deceased's primary health insurance carrier.

Health Insurance Carrier: _____

Address: _____

Number Street City State Zip Code

Settlement Options

If proceeds are payable to you, we will send a **lump sum payment** unless you elect an alternative method of distribution from the settlement options page of the policy.

I do not want a lump sum payment; instead, I would like to receive quotes on the settlement options indicated below.

_____

_____

Beneficiary Tax Certification

Enter your Taxpayer Identification Number in the appropriate box. For most individuals, this is your Social Security Number.

☐☐☐–☐☐–☐☐☐☐	☐☐–☐☐☐☐☐☐☐	☐☐–☐☐☐☐☐☐☐
Social Security Number	**Employer Identification Number**	**Tax Identification Number**

Check appropriate box for federal tax classification: ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership):_____

☐ Other: _____

Exemptions: Exempt payee code (if any): _____ Exemption from FATCA reporting code (if any): _____

Certification – 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), **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 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 a U.S. resident alien), **and**
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

You must cross out item (2) above if you *have been* notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Your signature on this form is certification that the Taxpayer Identification Number provided above is correct and complete.

Signature(s)

The undersigned beneficiary declares that the foregoing statements are true and complete. It is understood that the furnishing of forms by the company does not constitute an admission that there is any insurance in force or proceeds payable, nor does it constitute an admission of any liability.

Residents of States other than New York: Fraud Warning: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines, and denial of insurance in accordance with applicable state law. Please carefully review the "Claim Fraud Warning Statements" page, attached to and incorporated herein by reference.

New York Residents: Fraud Warning: 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.

The IRS does not require your consent to any provision of this document other than the above tax certification required to avoid backup withholding.

Signed at (City and State) _____ Date_____

Signature of Beneficiary or Personal Representative of the Beneficiary: _____

Print Name of Beneficiary or Personal Representative of the Beneficiary: _____

HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH AND OTHER INFORMATION

I hereby authorize the disclosure of information as set forth below.

Name of Decedent _____

Address of Decedent_____

Decedent's Date of Birth _____ Decedent's Social Security Number _____

I am authorizing the following to disclose information: Any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medical or medically related facility, insurance company, government agency, Social Security Administration, the MIB, Inc., the employer of the Decedent or any other organization, institution or person who has attended the Decedent or has any records or knowledge of his or her health.

To whom information may be disclosed: Security Mutual Life Insurance Company of New York ("Security Mutual"), or its representatives such as its attorneys, investigators, reinsurers or service providers.

Information to be disclosed: With respect to the Decedent any and all information regarding or related to any illness, including mental illness, drug or alcohol abuse or HIV/AIDS, injury, medical history, consultations, prescriptions, treatments, or benefits, and copies of all hospital and medical records, motor vehicle records, and employment and payroll records.

Purpose of disclosure: Information will be used by Security Mutual to determine eligibility for insurance benefits.

Expiration Date of this Authorization: This Authorization shall remain valid for the duration of the claim for benefits, unless I revoke it by written notice to Security Mutual at the address shown above.

Additional Statements

1. I agree that a copy of this Authorization shall be considered as effective and valid as the original.
2. I understand that my failure to sign this Authorization, or subsequent revocation of this Authorization, may result in denial of benefits by Security Mutual.
3. I understand that there is a potential for information used or disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer be protected by federal HIPAA privacy rules.
4. I understand that I may revoke this Authorization at any time by written notice to Security Mutual at the address shown above. I understand that a revocation is not effective to the extent that any person has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.
5. I understand that I may request to receive a copy of this Authorization.

Residents of States other than New York: Fraud Warning: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company or any other person. Penalties may include imprisonment, fines, and denial of insurance in accordance with applicable state law. Please carefully review the "Claim Fraud Warning Statements" page, attached to and incorporated herein by reference.

New York Residents: Fraud Warning: 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 material fact thereto, commits a fraudulent insurance act, which is 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.

_____ _____

Signature of Decedent's Personal Representative Date

_____ _____

Print Name of Decedent's Personal Representative Description of Decedent's Personal Representative's Authority

State of)

) ss.:

County of_____)

On the _____ day of _____ in the year _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

Notary Public

My commission expires: _____

CLAIM FRAUD WARNING STATEMENTS

The laws of the states beneath require the Company to provide the following statements:

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

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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, Louisiana and Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment for 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 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: 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, Idaho, Indiana and 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 a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to any 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: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

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.

Maine, Tennessee, Virginia and 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 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.

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 false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 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.

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 FINES 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with the 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

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.

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.