

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:

<i>Regular Mail:</i>	<i>Overnight Delivery/Certified Mail:</i>
Individual Claims	Individual Claims
PO Box 1625	100 Court Street
Binghamton, NY 13902-1625	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.



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



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.smlyn.com

HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

Insured's Name _____

Insured's Address _____
 Street City State Zip Code

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

Who I am authorizing to disclose information: Any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, health plan or other health care provider, medical facility, insurance company, government agency, consumer reporting agency, Social Security Administration, MIB, LLC, the Insured's employer or any other organization, institution or person who has attended the Insured or has any records or knowledge of the Insured or their health (the "Providers").

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

Information to be disclosed: The Insured's entire medical record, including any and all protected health information. Such information includes any and all information with respect to any illness, including mental illness (but excluding psychotherapy notes), the use of drugs, alcohol or tobacco, information relating to sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, including Human Immunodeficiency Virus (HIV) test results, injury, medical history, medical claims data, consultations, prescriptions, treatments or benefits, and copies of all hospital and medical records.

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

Expiration Date of this Authorization/Revocation: This Authorization shall remain valid for 24 months following my signature below, regardless of the Insured's condition and whether living or deceased, unless I revoke it in writing.

Additional Statements

1. I understand and acknowledge that the Providers may not refuse to provide treatment, payment, enrollment, or eligibility for health care services or other benefits if I refuse to sign this Authorization.
2. I understand my failure to sign this Authorization, or its subsequent revocation by me, may impair Security Mutual Life's ability to determine eligibility for benefits or process a claim for benefits under the Policy, and, in accordance with applicable law, may be a basis for denying a claim for insurance benefits.
3. I agree that a photocopied, facsimile or emailed copy of this Authorization shall be as valid as the original. I understand that I will receive a copy of this Authorization upon request.
4. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information and may be redisclosed by Security Mutual Life as required or permitted by law, and, except with respect to information obtained from MIB, LLC, to third parties such as reinsurers, the Insured's insurance agent or broker, and the general agent.
5. I understand that I may revoke this Authorization at any time, by mailing written notice to Security Mutual Life 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.

 Signature of Insured or Personal Representative

 Date

 Print Name of Insured or Personal Representative

Personal Representative's Legal Authority:

Custodial Parent Legal Guardian Executor of Estate of the Insured

Other Authorized Representative (please explain): _____

I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of the Insured's personal health information to MIB, LLC, at any time within twenty-four months from the date of this Authorization.

Signature of Insured or Personal Representative

Date

Print Name of Insured or Personal Representative

Personal Representative's Legal Authority:

Custodial Parent Legal Guardian Executor of Estate of the Insured

Other Authorized Representative (please explain): _____

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, Rhode Island and 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.
- California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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:** 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 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:** A 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.
- 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 any 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 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 a felony.
- 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.