DEATH CLAIM INSTRUCTIONS

WHEN YOU ARE FILING A CLAIM, PROCEED AS FOLLOWS:

Immediately complete the initial notice of death and mail direct to the **Life Claim Department**. *(To be sent only if we have not been previously notified.)*

Requirements:
(a) CLAIMANT'S STATEMENT
(b) CERTIFIED DEATH CERTIFICATE
(c) RETURN OF POLICY(IES)
(d) LOST POLICY AFFIDAVIT IF POLICY(IES) ARE LOST

Special Situations- See Reverse Side

The Association reserves the right to require further information of proof if necessary. Necessary investigation may cause some unavoidable delay.

NOTE: To assure prompt claim service, it is important that this Notice of Death be filled out and mailed immediately.

INITIAL NOTICE OF DEATH

To: UNITED TRANSPORTATION UNION INSURANCE ASSOCIATION, Life Claim Department, 24950 Country Club Blvd., Ste. 340, North Olmsted, OH 44070-5333. Telephone (216) 228-9400. Fax: (216) 228-0411.

This is to inform you of the death of____________________ Local__________

Date of Death__________ Place__________ Cause__________

Policy(ies)______________________________

Beneficiary(ies)______________________________

Date____________________

____
Person Reporting Death-Title

Attach newspaper account of death, if available.

____
Address

Information for Use in Various Special Situations

1. **MORE THAN ONE BENEFICIARY:**
Each beneficiary must sign the claimant's statement or if more convenient, a separate statement be completed and signed for each.

2. **ESTATE BENEFICIARY:**
The claimant's statement should be completed and signed by the Executor or Administrator. The current certificate of appointment must be submitted.

3. **MINOR OR INCOMPETENT BENEFICIARY:**
The claimant's statement should be completed and signed by the guardian of the Estate of the beneficiary. A current certificate of appointment must be submitted.

4. **BENEFICIARY DECEASED:**
If any of the beneficiaries named in the policy is deceased, a certified copy of the death certificate of such deceased beneficiary must accompany the claimant's statement.

5. **AGREEMENT:**
   a) If the policy is assigned as collateral, the claimant's statement should be completed and signed by the assignee and should be accompanied by statement of interest of the assignee and verified by the beneficiary. If entire amount not claimed by the assignee, the beneficiary should also sign claimant's statement. If assignee has no further interest, a formal release completed and signed by the assignee should be furnished.

   b) If the policy is assigned on the Americal Bankers Association Form, the assignee has the sole right to collect the entire proceeds. The assignee should complete and sign the claimant's statement. If the assignee does not expect to receive the entire proceeds, a statement should be submitted setting forth the amount expected and authorizing the association to pay the balance to the beneficiary. The balance will be paid to the beneficiary and in this event the beneficiary should also sign the claimant's statement.

6. **FAMILY POLICY:**
If child or spouse deceased, beneficiary should complete and sign the claimant's statement. If insured deceased, beneficiary should complete claimant's statement and furnish statement of all living children, stepchildren and legally adopted children and dates of birth. A statement should also be furnished as to whether or not the wife is pregnant.

7. **CORPORATE BENEFICIARY:**
The claimant's statement must be completed and signed by an officer of the corporation who has authority.

8. **BENEFICIARY IS ALL CHILDREN BORN OF MARRIAGE:**
A statement from the children and a disinterested person listing all of the children born of the marriage. A death certificate should be furnished if any child is deceased.

LIFE INSURANCE CLAIM-CLAIMANT'S STATEMENT

Policy Number(s)	Amount(s)
____________________	$ ______________
____________________	$ ______________

1. (a) Deceased's name in full ______________________________
   (b) Residence at death ______________________________
2. (a) Date of birth ____________________ Place ______________
   (b) Source from which birthdate obtained ______________________________
3. (a) Date of death ____________________ Place ______________
   (b) Cause ____________________ Natural Accidental Other

NOTE: IF THIS POLICY HAD BEEN IN FORCE FOR MORE THAN TWO YEARS AT INSURED'S DEATH, QUESTIONS 4 AND 5 MAY BE OMITTED.

4. (a) When did deceased first complain or give indication of last illness? ______________
   (b) When did deceased first consult a physician for last illness? ______________
5. Name and addresses of all physicians or practitioners who attended or prescribed for deceased during five years preceding death. Attach separate sheet if necessary.

Name	**Address**	**Dates of Attendance**	**Disease or Condition**

6. I/we understand and agree that the furnishing of this form or the furnishing of any form supplemental thereto, does not constitute and will not be considered as a waiver of any of the Association's rights with respect to liability under the policy, or the identity of persons entitled to benefits payable thereunder or of any other rights or defenses available to the Association.

   I hereby authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company or other person, organization or institution that has any records or knowledge of the deceased, to give to the United Transportation Union Insurance Association, or its representative, any such information. A photocopy of this authorization shall be as valid as the original.

   Date: ______________

Witness	**Claimant's Signature**	**Relationship To Deceased**	**Claimant Date of Birth**	**Claimant SS No.**
1.__________	1.__________			

1. **Claimant's Address** ______________________________
   Street *City* *State* *Zip*
1. **Claimant's Telephone No.** ______________

Witness	**Claimant's Signature**	**Relationship To Deceased**	**Claimant Date of Birth**	**Claimant SS No.**
2.__________	2.__________			

2. **Claimant's Address** ______________________________
   Street *City* *State* *Zip*
2. **Claimant's Telephone No.** ______________

PLEASE ATTACH POLICY OR POLICIES AND MEDICAL PROOF OF DEATH

If policy or policies are lost, please complete the reverse side of form.

WARNING

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. (O.R.C.-Sec. 3999.21)

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.

UNITED TRANSPORTATION UNION INSURANCE ASSOCIATION
A Fraternal Benefit Society
24950 Country Club Blvd., Ste. 340
North Olmsted, Ohio 44070-5333
Telephone: (216) 228-9400
Fax: (216) 228-0411

LOST POLICY AFFIDAVIT REGARDING DEATH CLAIMS

I ______________________________ being first duly sworn, state that I am the ____________________
Name of Beneficiary *Relationship*

of the deceased ______________________________. I further state that insurance policy #__________
Insured

was issued and I am the beneficiary named in the policy.

I further state that the policy cannot be located or I cannot obtain possession of it. I agree to save harmless the United Transportation Union Insurance Association from all liability, cost or expense on account of the payment of the proceeds of the policy. In the event I obtain possession of the policy, I will forward it to the United Transportation Union Insurance Association.

______________________________ ______________________________
Witness Signature of Beneficiary

____
Address of Beneficiary