



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.**

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.)
- Certified death certificate.
- All original enrollment forms and change of beneficiary cards.
- For AD&D and Seat Belt claims, attach 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 and the Standard Secure Access account.

Beneficiaries may receive their funds via Standard Secure Access (SSA) in accordance with the terms of the group policy. SSA is a convenient, interest-bearing checking account in which life insurance proceeds are deposited. With SSA, the beneficiary is able to earn a competitive rate of interest on the life insurance proceeds while taking the time to weigh important financial decisions that often follow the death of a loved one.

The Beneficiary will be mailed a checkbook once the claim is approved. In addition, all SSA accountholders have access to 24-hour customer service via a voice response unit (VRU) and a dedicated customer service team.

Please make sure all required forms are completed and returned to our office. Our examination of the claim will begin when all completed forms are received. Should you have questions, our office is available to assist you. Please call **(800) 628-8600** or e-mail us at **lifebenefits@standard.com**.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____					
Date of Death:				Reason member ceased working: <input type="checkbox"/> Death <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain) _____							
If Dependent Claim, Name of Member:				Last month premium was paid for member or dependent:							
Group Policy No.:		Insurance Class (see contract):		Monthly or annual salary:							
645783				\$							
Occupation:				Date of last salary increase:							
Amount of insurance claimed:				Salary prior to increase:							
Basic Life \$ _____		Dependents Life \$ _____		\$							
Additional Life \$ _____		Other (specify) \$ _____		Usual number of hours employee worked per week:							
Accidental Death \$ _____				Amount of monthly premium paid for the insured:							
Member also had the following claims with Standard Insurance Company: (check all that apply)				Member was: (check all that apply)							
<input type="checkbox"/> Long Term Disability				<input type="checkbox"/> Full-time <input type="checkbox"/> Union <input type="checkbox"/> Hourly							
<input type="checkbox"/> Short Term Disability				<input type="checkbox"/> Part-time <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried							
<input type="checkbox"/> Waiver of Premium				<input type="checkbox"/> Commissioned <input type="checkbox"/> Active <input type="checkbox"/> 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:											
<p>In addition to this form, the following items are required:</p> <ul style="list-style-type: none"> ● Beneficiary Statement. ● Original enrollment forms and any subsequent beneficiary changes. ● Certified death certificate. ● For AD&D and Seat Belt Claims, newspaper clippings, police and accident reports, or other information regarding the accident. 											
Acknowledgment											
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					
Benefit Administrator's Name (Please print)						<p>Dade County Fire Fighters Insurance Trust Fund Name of Employer or Association</p> <p>8000 NW 21st Street, Suite 222 Street Address</p> <p>Miami FL 33122 City State Zip Code</p>					
() Phone No.											
<p>Payments paid via SSA will be sent directly to beneficiary, payments paid via check will be sent to policyholder, unless requested otherwise.</p>											

Some states require us to provide the following information to you:

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.

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 a 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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