THE UNITED STATES LIFE Insurance Company In the City of New York

A USLIFE COMPANY

For **DEPENDENTS** of employees only

PROOF OF GROUP DEATH CLAIM

AS REQUIRED BY LAW, 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 ACT, WHICH IS A CRIME.

STATEMENT OF POLICYHOLDER

Name of Employee	Address of Employee	Amount of Insurance for Dependent

Group Policy Number	Certificate Number	Name and Address of Employer	Telephone Number

Duration of Employment From: Through:	Last Day of Full Time Active Work for Employer	Reason for Stopping Work

Full Name of Deceased Dependent	Relationship to Employee	Dependent's Date of Birth

Is Dependent Married?	Date of Death	If Contributory Insurance, to What Date has Employee's Contribution Been Paid?

If Full Time Student, Name and Address of School Attended

Is Dependent Employed Full Time? ☐ Yes ☐ No — If Yes, Name and Address of Dependent's Employer

Name of Beneficiary	Relationship	Age

Signature of Policyholder's Official Representative	Title	Current Date

Print Name of Individual Whose Signature Appears Above	Send Check To

CLAIMANT'S STATEMENT

Full Name of Deceased	Date of Birth	Date of Death

Cause of Death	Place of Death

When did deceased first complain of, or give indication of his last illness? Date	When did deceased first consult a physician for his last illness? Date

In What Capacity do you Claim This Insurance? (If Administrator, executor or guardian, attach copy of court order of appointment.)

Your Date of Birth	Your Social Security Number	If lump-sum settlement is **NOT** elected, indicate Optional Mode of Settlement desired.

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I hereby authorize and request any hospital, physician, pharmacist, employer, insurance company or other person or entity to whom this is presented to furnish The United States Life Insurance Company In the City of New York or its representative, any and all information and records (or copies thereof) it may desire, specifically to include testing and/or treatment of Human Immunodeficiency (HIV) or AIDS, concerning the deceased and further agree that such information or records shall constitute and are hereby made a part of the Proofs of Death.

_______________ 19____ *DATE* — _______________ *SIGNATURE*

_______________ *WITNESS* — _______________ *ADDRESS*

_______________ *ADDRESS* — _______________ *ADDRESS*

_______________ *ADDRESS* — _______________ *TELEPHONE*

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

INSTRUCTIONS

To Avoid Unnecessary Delay In Processing Claims, Please Complete All Blank Areas And Sign Form.

The **STATEMENT OF POLICYHOLDER** should be completed and signed by an authorized representative of the group policyholder (employer, union, association, welfare fund or other organization through which the insurance was obtained).

The **CLAIMANT'S STATEMENT** should be completed and signed by the beneficiary (usually the insured employee). Anyone other than a family member may sign as witness to the beneficiary's signature.

A copy of the **ENROLLMENT CARD**, if available, and a **CERTIFIED** copy of the **DEATH CERTIFICATE** must accompany this form. Submit the claim proofs to:

THE UNITED STATES LIFE Insurance Company
Attention: Policy Benefit-Life Department
3600 Route 66 • PO Box 1580
Neptune NJ 07754 1580