SERB NATIONAL FEDERATION — Српски Народни Савез

Life Insurance Death Benefit Claim Form

Life Insurance Policy # _____ Lodge # _____

Deceased's Information:

_____ ____ _____ ____ ____ - ____ - _____
First Name MI Last Name Gender Date of Birth

_____ _____ ____ _____ ____ - ____ - _____
Street Address City State Zip code Date of Death

_____ - _____ - _____ Citizen of the U. S. A. - ☐ YES or ☐ NO; If no, _____ _____
Social Security Number Country of Citizenship Cause/Manner of Death

Beneficiary Information:

_____ ____ _____ ____ _____ - _____ - _____
First Name MI Last Name Gender Phone Number

_____ _____ ____ _____ _____
Street Address City State Zip code E-Mail Address

_____ - _____ - _____ ____ - ____ - _____
Social Security Number Date of Birth

Beneficiary's relationship to Decedent: I am filing this claim as:

☐ An individual who is a named beneficiary under the policy, relationship _____ ☐ Male OR ☐ Female

☐ A Trustee of a Trust, which is a named beneficiary under the policy;

☐ An Executor of an Estate, which is named beneficiary under the policy

☐ Other _____ Citizen of the U. S. A. - ☐ YES or ☐ NO; If no, _____
Country of Citizenship

To the best of your knowledge, please provide information as to any additional insurance in-force on the decedent's life.

_____ _____ _____ _____
Company Face Amount Company Face Amount

_____ _____ _____ _____
Company Face Amount Company Face Amount

- I hereby attest that the original policy is lost . ☐ YES or ☐ NO, If yes, I further attest, to the best of my knowledge, that the above mentioned policy has not been assigned to any person or entity.
- I understand that if this claim is for a policy within its contestable period and/or the manner of death is suspect, the Information Disclosure supplement form will need to be completed and submitted with this document.
- By signing below, I hereby represent that the statements and answers included herein are full, complete, and true, to the best of my knowledge and belief. Furthermore, I understand that the SNF does not offer financial, tax, and/or legal advice and realize there may be tax implications as a result of this beneficiary request.

_____ _____ - _____ - _____
Beneficiary's/Claimant's Signature Date

_____ _____
Title *(if applicable)* Relationship to Deceased

A Certified copy of the Death Certificate must be submitted with this form to process the claim. Failure to do so will delay processing.

Please Note: 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. See back of this form regarding important information regarding that may apply in your state.

HOME OFFICE USE:

_____ _____ - _____ - _____
Signature of Approval Date

State Specific Fraud Warnings

For Residents of 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.

For Residents of Arkansas, New Mexico, & Rhode Island - Any person who knowingly present 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 is prison.

For Residents of 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 a state prison.

For Residents of 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 company proceeds shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies.

For Residents of the District of Columbia - WARNING: It is a crime to provide false or misleading information to an issuer 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.

For Resident of Florida - Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of IN - Any person who knowingly and with intent to defraud or deceive an insurer files a false statement of claim containing any false, incomplete or misleading information commits a felony.

For Residents of 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.

For Residents of Louisiana, Maine, Tennessee, Virginia, & 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.

For Residents of 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.

For Residents of Minnesota, Ohio, & Oklahoma - Warning: Any person who, with intent to defraud or knowing that he/she 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.

For Residents of New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For Residents of 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.

For Residents of Pennsylvania, & West Virginia - 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 the person to criminal and civil penalties.

Information Disclosure - Authorization Supplement to Death Benefit Claim Form

Thank you for your recent submission of a life insurance beneficiary claim form.

A. During our claim process, a consumer investigation report may be obtained that may contain information concerning personal characteristics, mode of living, and/or general reputation. This information may be obtained through personal interviews of your acquaintances, neighbors, and/or friends. Further information, as to the scope of these inquiries, can be provided to you upon a written request to the SNF home office.

B. Any information with respect to the claim process will be treated as confidential. However, we can make a report to the MIB Inc., (MIB is a not-for-profit membership organization of life insurance companies that operates an information exchange in behalf of its members). If an application is made to another MIB member for either life or health insurance coverage; or submitted a claim for benefits to a MIB member; the MIB (upon request) will supply the MIB member with the information it has on file. The MIB, upon written request from you, will arrange disclosure of any information it may have in your file (medical information will only be disclosed to your attending physician). If you suspect the accuracy of this information is incorrect, you may contact the MIB to seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, phone 866-692-6901. We may also release information in our file to other life insurance companies and/or our reinsurer(s) to whom application may be made for life and/or health coverage; or to whom a claim for benefits may be submitted.

A COPY OF THIS NOTIFICATION/AUTHORIZATION MUST BE GIVEN TO THE CLAIMANT WHEN REQUIRED AND A COPY OF THIS FORM (completed) MUST ACCOMPANY THE ORGINAL LIFE INSURANCE DEATH CLAIM FORM WHEN IT IS SUBMITTED.

I Authorize the following that may have any records and/or information regarding me or my minor children, including driving records, controlled substance and/or alcohol use, to provide these records of information to: SNF; its legal representative, or its reinsurers:

- Any licensed physician or medical practitioner
- Any hospital or clinic, medical or medically related facility
- The MIB Inc., consumer reporting agency or other such organization, insurer, or reinsurer, employer, institution, government agency, or person

I also Authorize that:

- All sources stated above expect the MIB to provide such information to a consumer reporting agency or other agency employed by the SNF to obtain such information.
- The SNF or its reinsurers, to release such information to the MIB, other insurers wherein my minor children and/or myself have insurance, to whom I or they may apply for insurance, or to whom a claim may be submitted; or as may be required by law.
- The SNF to obtain an investigative consumer report.

I Understand that:

- Upon request, I or my duly authorized representative may receive a copy of the authorization
- The information obtained by this authorization will be used to determine my eligibility and/or my minor children's eligibility for insurance, or to determine the eligibility for benefits in the event of a claim.
- Any information obtained on the application about a medical consultation or informational visit concerning AIDS or ARC, as opposed to the diagnosis or treatment of AIDS or ARC, will never be used to underwrite coverage on a proposed insured.

I Agree that this authorization or a copy shall be valid for a period of 30 months ***(If written in the state of INDIANA 24 months)*** from the date signed below.

_____	_____
Printed Name of Beneficiary/Claimant	Date
_____	_____
Signature of Beneficiary/Claimant	Date
_____	_____
Title of Claimant (if Applicable)	Date
_____	_____
Witness - Producer/Agent	Date