Foresters Financial

P.O. Box 179
Buffalo, NY 14201-0179

T 800 828 1540
F 877 329 4631

foresters.com

Statement of Claim for Death Benefits

On behalf of Foresters Financial™, please accept our condolences for your loss. We understand that this is a difficult time for you and your family. Please know that we will make every effort to process your claim promptly. We strive to provide service of the highest standards and take pride in assisting you with your claim for benefits.

To ensure timely handling of your claim, it is important that your submission contain all necessary information requested in the Claimant's Statement.

NOTE: Since the death occurred within the first 2 years of the issue date of this certificate, this claim is considered contestable.

Please review the following checklist prior to submitting your claim:

- ☐ Complete all sections of the Claimant's Statement and sign where required. If there is more than one claimant, please ensure that a separate Claimant's Statement is completed by each claimant. Copies can be made of this document. **Important: Be sure to complete Section 3 requesting primary treating physician and medical facility information.**
- ☐ Complete the enclosed Authorization for Disclosure of Medical and Health Related Information.
- ☐ Obtain a certified copy of the decedent's death certificate. **Note:** Only one certified death certificate is required per decedent with multiple certificates and/or claimants. Include the original certificate, if available. Death Certificates become a part of the claim file and will not be returned.
- ☐ If the last known beneficiary has died, please provide us with a copy of the beneficiary's death certificate.
- ☐ If the Claimant's name has changed please provide legal documentation supporting the change.
- ☐ If the claim form is to be completed by an Executor, Administrator or a Legal Guardian, a copy of the filed document supporting that appointment must be submitted with the Claimant's Statement.
- ☐ If the claim form is to be completed by a Trustee, please be sure to include the Tax I.D. of the trust or the Social Security Number of the Trustee. Additionally, please provide a copy of that portion of the trust referring to the successor trustee(s) along with a statement that the trust is currently in effect.
- ☐ If any portion of the death benefit will be assigned, please include the funeral assignment and a copy of the funeral bill.
- ☐ **Provide only if the death occurred as a result of an accident, suicide or homicide.**
  If the cause of death is other than natural, in addition to the Authorization and completed Claimant's Statement, submit a copy of the police report, coroner's report and/or toxicology report, along with a copy of the decedent's driver's license and any other relevant information that may help us complete our investigation. Further investigation will be made to confirm the circumstances surrounding the death.
- ☐ **Complete only if the death occurred outside the United States or Canada.** Please submit the official death certificate issued in the country where the death occurred and provide a notarized translation of the death certificate. We also require the enclosed Foreign Death Questionnaire be completed and submitted along with a copy of the passport. If the decedent was a U.S. Citizen, we will also need:
  - A completed Report of the Death of an American Citizen Abroad (may be obtained from the local US Embassy or Consulate),
  - A Physician's Statement, completed and signed by the doctor who certified the death.

Please understand your claim may be delayed if incomplete forms are submitted or if additional information is required by Foresters. We will contact you as soon as reasonably possible in the event additional information is needed. Please print clearly.

Certificate underwritten by The Independent Order of Foresters (The IOF), a fraternal benefit society. Foresters Financial and Foresters are the trade names and trademarks of The IOF and its subsidiaries.

SECTION 1: LIST ALL CERTIFICATE NUMBER(S) BEING CLAIMED

LIST CERTIFICATE NUMBER(S) FOR WHICH YOU ARE MAKING CLAIM:

A) B) C) D)

SECTION 2: DECEDENT INFORMATION

DECEASED NAME (FIRST, MIDDLE, LAST)

ADDRESS (STREET, CITY, STATE, ZIP CODE)	HOW LONG IN STATE

DATE OF BIRTH (MM/DD/YYYY)	DATE OF DEATH (MM/DD/YYYY)	CAUSE OF DEATH

PLACE OF BIRTH	STATE OF RESIDENCE PRIOR TO DEATH

IF DEATH OCCURRED AS A RESULT OF AN ACCIDENT, SUICIDE OR HOMICIDE, PLEASE PROVIDE DETAILS:

TO THE BEST OF YOUR KNOWLEDGE, HAD THE DECEASED EVER USED NICOTINE PRODUCTS? ◯ YES ◯ NO ◯ UNKNOWN

IF "YES" PROVIDE DETAILS (TYPE USED, DATE LAST USED, ETC.):

SECTION 3: MEDICAL INFORMATION

PLEASE PROVIDE THE NAME AND ADDRESS OF THE PRIMARY TREATING PHYSICIAN OR MEDICAL FACILITY WHERE THE DECEASED WAS TREATED DURING THE PAST 5 YEARS.

1. NAME OF PHYSICIAN/FACILITY

ADDRESS (STREET, CITY, STATE, ZIP CODE)	PHONE NUMBER

DATES OF TREATMENT

FROM TO

REASON(S) FOR TREATMENT

2. NAME OF PHYSICIAN/FACILITY

ADDRESS (STREET, CITY, STATE, ZIP CODE)	PHONE NUMBER

DATES OF TREATMENT

FROM TO

REASON(S) FOR TREATMENT

IF ADDITIONAL SPACE IS REQUIRED, ATTACH SEPARATE SHEET AND SIGN AND DATE.

SECTION 4: CLAIMANT'S STATEMENT

NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO DECEASED
DATE OF BIRTH	* SOCIAL SECURITY/TAX I.D. NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER	EMAIL ADDRESS

INSURANCE, IF ANY, WITH OTHER COMPANIES ON LIFE OF DECEASED:

NAME OF COMPANY	AMOUNT	DATE POLICY ISSUED	BENEFICIARY

Proceeds are paid in a lump sum unless otherwise requested. For information on alternative settlement options, please contact Claims Services.

*This information should be filled in by the claimant as it may be required for reporting any taxable income paid to the claimant. If the claimant has never been assigned a number, insert "No Number". If the estate of the deceased is the claimant, the deceased's social security number/Tax I.D. number (I.R.S.) should be filled in. If the Taxpayer I.D. or Social Security Number is not supplied, the certificate(s) may be subject to federal and state withholding.

Under penalties of perjury, I certify that:
(a) The taxpayer ID or Social Security number shown on this form is my correct taxpayer identification number;
(b) I am not subject to backup withholding due to failure to report interest and dividend income; and
I am a US Citizen (including a US resident alien)

You must cross out any of the above items (letters a through c) that do not apply to you.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Notice For Contracts Issued in and Residents of Illinois Only
Unless a payment is made by the Company on this claim within thirty-one days after receipt of due proof of loss, interest on the claim will accrue at a rate of 10% from the date of the death to the date of the payment for the total amount payable.

Certification (Notarization not required)

I certify that the above answers are full and true to the best of my knowledge and belief. I have read the applicable Fraud Warnings provided in this form.

California residents: 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.

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.

Confidentiality: You can read our Privacy Policy at Foresters.com.

CLAIMANT NAME (PRINT)	CLAIMANT SIGNATURE	DATE
WITNESS NAME (PRINT)	WITNESS SIGNATURE	DATE

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FRAUD WARNING NOTICES – PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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 the 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: 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 fraud 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 or claim or an application containing any 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 the 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.

LOUISIANA: 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.

MAINE: 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 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 RSA 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.

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.

OREGON: 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 material false or deceptive 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.

PENNSLYVANIA: 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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are [sic] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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 include imprisonment, fines and denial of insurance benefits.

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.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL AND HEALTH-RELATED INFORMATION

This authorization meets the requirements under the Health Insurance Portability and Accountability Act (HIPAA)

PATIENT INFORMATION

PATIENT/INDIVIDUAL NAME (PLEASE PRINT)			
DATE OF BIRTH (MM/DD/YYYY)	SSN	PHONE	EMAIL
ADDRESS (STREET, CITY, STATE, ZIP CODE)			

FOR HOME OFFICE USE ONLY (PLEASE DO NOT COMPLETE)

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE PATIENT'S PROTECTED HEALTH INFORMATION:

PERSON/ORGANIZATION NAME

ADDRESS (STREET, CITY, STATE, ZIP CODE)

I authorize any health plan, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to the patient listed above or on the patient's behalf to disclose the entire medical record and any other protected health information concerning the patient to The Independent Order of Foresters™ (Foresters), and its agents, employees and authorized representatives. This includes information on the diagnosis of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of behavioral and mental health services and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements which have been made to restrict the patient's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the patient's entire medical record without restriction. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal or state law. However, I also understand that the federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

This protected health information is to be disclosed under the Authorization so that Foresters may: 1) administer claims and determine or fulfil responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage with Foresters.

This authorization shall remain in force for 24 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so by sending a request for revocation in writing to Foresters, Attention: Claims at P.O. Box 179, Buffalo, NY 14201-0179. I understand that this revocation will not apply to the insurer when the law provides the insurer with the right to contest a claim under my policy.

SIGNATURE OF PATIENT/BENEFICIARY (OR LEGAL REPRESENTATIVE IF NO BENEFICIARY)	SIGNATURE OF WITNESS
DATE: (MM/DD/YYYY)	DATE: (MM/DD/YYYY)
SIGNATURE OF INFORMANT ON DEATH CERTIFICATE (IF DIFFERENT THAN BENEFICIARY OR LEGAL REPRESENTATIVE)	DATE: (MM/DD/YYYY)

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state and federal law.

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AFFIDAVIT FOR THE RELEASE OF MEDICAL RECORDS

CERTIFICATE NUMBER:

My _____,
(RELATION TO MEMBER)

_____ died on _____
(NAME OF MEMBER) (INCLUDE DAY, MONTH, AND YEAR)

I, _____, am his/her _____,
(NAME) (RELATIONSHIP)

Next of Kin and the primary beneficiary. I state:

1. That no Personal Representative has been appointed for the decedent's estate in this state or elsewhere and no application for such an appointment is pending in this state or elsewhere.
2. That I am the person entitled to preference in appointment.
3. That this affidavit is made in support of the undersigned request for the release of medical records.

NAME (FIRST, MIDDLE, LAST)

ADDRESS (STREET, CITY, STATE, ZIP CODE)

DATE OF BIRTH:	* SOCIAL SECURITY/TAX I.D. NUMBER:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE THAT THE FOREGOING IS TRUE AND CORRECT.

Dated: _____ Signature: _____

Subscribed and sworn to before me: _____

A Notary Public on: _____
(DATE)

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