

Statement of Death for Group Life and Accidental Death Benefits

LifeWise Assurance Company
P.O. Box 2272
Seattle, WA 98111-2272
(425) 918-4575

LIFEWISE

ASSURANCE COMPANY

Life | Disability | Stop Loss

IMPORTANT: READ CAREFULLY

1. Complete the Statement of Employer section.
2. Have the claimant complete the Statement of Claimant section.
3. Attach a certified death certificate to the claim form. If accidental death benefits are being claimed attach a copy of investigating officer's report and a coroner's report if applicable.
4. Attach the original enrollment card and all Change of Beneficiary forms to the claim form. If benefits are salary based, attach a copy of payroll records covering the last six months.
5. Mail the claim form and all supporting documents to the above address.

STATEMENT OF EMPLOYER

NAME OF DECEASED		DATE OF BIRTH / /		SOCIAL SECURITY NUMBER	
LEGAL RESIDENCE AT TIME OF DEATH				EMPLOYER POLICY NUMBER	
EFFECTIVE DATE OF COVERAGE / /	AMOUNT OF INSURANCE	DATE FIRST ENTERED EMPLOYMENT / /		OCCUPATION	
DATE OF LAST ACTIVE SERVICE / /	REASON FOR LEAVING WORK	BASIC ANNUAL EARNINGS AT DEATH (Please attach most recent payroll records)			DATE OF DEATH / /
FULL-TIME <input type="checkbox"/> Yes <input type="checkbox"/> No		PART-TIME <input type="checkbox"/> Yes <input type="checkbox"/> No		HOURS WORKED PER WEEK	
IF DEPENDENT CLAIM: Name of Employee _____				DEPENDENT RELATIONSHIP TO INSURED	
WAS INSURED ON DISABILITY OR WAIVER OF PREMIUM WITH LIFEWISE ASSURANCE COMPANY? <input type="checkbox"/> Yes <input type="checkbox"/> No				EMPLOYEE SOCIAL SECURITY NUMBER	
NAME OF EMPLOYER		SIGNATURE AND TITLE		DATE / /	
MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE ()	

STATEMENT OF CLAIMANT

NAME AND RELATIONSHIP OF BENEFICIARY		TELEPHONE	DATE OF BIRTH OF BENEFICIARY / /
ADDRESS OF BENEFICIARY (STREET, CITY, STATE, and ZIP CODE)			SOCIAL SECURITY NUMBER

SETTLEMENT INFORMATION

OPTIONAL MODES OF SETTLEMENT:

If your settlement proceeds exceed the current applicable minimum of \$2,500, **an interest bearing money market account (Insured Benefit Account) will be opened for you at State Street Bank and Trust Company, Boston, Massachusetts.** Upon approval for payment of the benefits, you will promptly receive personalized checks and may **immediately** utilize all or a portion of those funds by writing checks against the account. The funds in the account, meanwhile, will earn interest at a competitive variable rate and will be insured for the full amount permitted by the FDIC. And, there are no monthly fees or service charges associated with the account. By signing below, you instruct LifeWise Assurance Company to transfer the settlement proceeds to State Street Bank and Trust Company, and you authorize State Street Bank and Trust Company to obtain any references necessary, and to exchange information with LifeWise Assurance Company concerning your Insured Benefit Account. For a current quote on the interest being paid thereon, or for additional information regarding this or any other settlement option call (425) 918-4575. Benefits will be paid in this manner unless an optional mode of settlement is selected.

- OPTION A: Insured Benefit Account, as described above.
- OPTION B: Interest only, with right of withdrawal interest payable: Annually _____ Semiannually _____ Quarterly _____ Monthly _____
- OPTION C: Fixed installments in equal _____ installments of \$ _____.
- OPTION D: Single Benefit Payment.

UNDER PENALTIES OF PERJURY: I certify (1) that the number shown on this form is my correct taxpayer identification number, and (2) that I am not subject to backup withholding as a result of a failure to report all interest or dividend, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. (If subject to backup withholding, please cross out #2.)

AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the above statements are true and complete to the best of my knowledge. I authorize any provider of health care, insurance company, physician, hospital or government agency to disclose and furnish to LifeWise Assurance Company any information or records relating to this claim. Any information provided is to be used only to determine eligibility for benefit under this insurance policy.

Claimant's Signature _____ Date ____/____/____ Relationship to Deceased _____