NSS Life®
® Family Matters...

SENIOR SAFEGUARD DEATH CLAIM

We want to ensure you receive your benefit payment promptly, so please complete the applicable sections and be sure to enclose the documentation requested. Each named beneficiary will need to complete a separate claim form. ***Please refer to page 9 to ensure that all sections have been completed and all documentation is included prior to mailing. Please type or print clearly to avoid any delays in processing.***

SECTION 1: ABOUT THE DECEASED

Name: _____
FIRST MIDDLE LAST

Contract Number(s) you are claiming benefits for: _____

Social Security Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Death: _____

Primary Care Physician: _____
NAME

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

The original contract is: ☐ Enclosed ☐ Lost or Destroyed

PLEASE INCLUDE AN ORIGINAL CERTIFIED DEATH CERTIFICATE WITH THIS CLAIM FORM.

SECTION 2: CLAIMANT DETAILS

Individual Beneficiary Name: _____
FIRST MIDDLE LAST

Non-Individual Beneficiary Name (trust, estate, charity): _____

Social Security Number or EIN for Beneficiary: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternative Phone #: _____

Email Address: _____

Date of Birth: _____ Relationship to Deceased: _____

In what capacity are you claiming benefits?

- ☐ Named Beneficiary
- ☐ Trustee (Include a copy of the Trust Agreement)
- ☐ Executor, administrator, or personal representative of the estate (Include court appointment)
- ☐ Charity or Corporation (Include copy of the corporate resolution)
- ☐ On behalf of a minor child (Include court documents establishing guardianship)
- ☐ As Attorney-in-Fact under a Power of Attorney (Include copy of Power of Attorney)
- ☐ Other: _____

SECTION 3: DEATH BENEFIT OPTIONS

Details for all death benefit options can be found in the contract. Consider the death benefit options carefully as once we have processed your request, it is not reversible.

Select one of the 2 options below:

☐ **Option 1:** Receive Payments Over 60 Months

If you select this option, you will receive monthly payments for 60 months. If you should die after payments begin, your beneficiary will receive the remaining payments.

PLEASE INCLUDE A COMPLETED DIRECT DEPOSIT AUTHORIZATION WHEN THIS OPTION IS SELECTED.

Remember to complete Section 4: Beneficiary Designation. You will need to name a new beneficiary. The beneficiaries of the original contract owner are no longer valid, so if you do not designate beneficiaries, the death benefit will go to your estate.

☐ **Option 2:** Receive a Lump Sum Payment

If you select this option, you will receive a single payment by check. Your lump sum payment will be equal to the commuted value as provided in the contract.

SECTION 4: BENEFICIARY DESIGNATION

You do not need to complete this section if you selected Option 2: Receive a lump sum payment.

- Percentages must total 100%
- If you have more than 4 beneficiaries, please list them on a separate sheet, signed and dated by you.
- If a beneficiary is not designated, then we will pay any remaining benefits to your estate.
- If you do not indicate the % you would like each beneficiary to receive, the surviving beneficiaries will share equally.

Beneficiary 1: Percentage: _____ % Select one: ☐ Primary ☐ Contingent

Individual Beneficiary Name: _____
FIRST MIDDLE LAST

Non-Individual Beneficiary Name (trust, estate, charity): _____

Social Security Number or EIN for Beneficiary: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternative Phone #: _____

Email Address: _____

Date of Birth: _____ Relationship: _____

Beneficiary 2: Percentage: _____ % Select one: ☐ Primary ☐ Contingent

Individual Beneficiary Name: _____
FIRST MIDDLE LAST

Non-Individual Beneficiary Name (trust, estate, charity): _____

Social Security Number or EIN for Beneficiary: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternative Phone #: _____

Email Address: _____

Date of Birth: _____ Relationship: _____

Beneficiary 3: Percentage: _____ % Select one: ☐ Primary ☐ Contingent

Individual Beneficiary Name: _____
FIRST MIDDLE LAST

Non-Individual Beneficiary Name (trust, estate, charity): _____

Social Security Number or EIN for Beneficiary: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternative Phone #: _____

Email Address: _____

Date of Birth: _____ Relationship: _____

Beneficiary 4: Percentage: _____ % Select one: ☐ Primary ☐ Contingent

Individual Beneficiary Name: _____
FIRST MIDDLE LAST

Non-Individual Beneficiary Name (trust, estate, charity): _____

Social Security Number or EIN for Beneficiary: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternative Phone #: _____

Email Address: _____

Date of Birth: _____ Relationship: _____

SECTION 5: CERTIFICATION OF TAXPAYER IDENTIFICATION NUMBER (SUBSTITUTE W-9)

If you are claiming death benefit payments as a U.S. person, the IRS requires you to agree to the following statements.

For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Under penalty of perjury, I certify that:

1. The Taxpayer Identification Number shown on this form is my correct taxpayer identification number or I am waiting for a number to be issued to me.

If the IRS has notified you that you are subject to backup withholding because you failed to report interest or dividends on your tax return, you must cross out item 2 below.

2. I am not subject to backup withholding because:
   a. I am exempt from backup withholding, or
   b. I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
   c. the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined above), and

4. I am exempt from FATCA reporting.

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

SECTION 6: FRAUD NOTICE

IMPORTANT: This is part of the claim form. Please review the applicable fraud notice required by your state of residence.

All states other than those listed below: 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.

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 state law.

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.

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.

California - For your protection California law requires the following to appear on this form. Any person who knowingly presents 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 - 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 proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

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.

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

Indiana - Any person who knowingly and with 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 and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and 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.
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.
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 makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania - 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. If aggravating circumstances are 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.
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.

SECTION 7: SIGNATURES

As the authorized signer, please sign and date below in the appropriate space. If you do not sign and date this page, we will not be able to process your claim. NSS Life reserves the right to request additional information we consider necessary to pay the claim.

By signing, I acknowledge and represent that all information provided in this claim form is true, accurate, and complete to the best of my knowledge and I authorize NSS Life to process the requested death benefit payment as indicated. I am aware that this transaction is NOT reversible.

Your Signature: _____ Signed Date: _____

OR

Trustee's Signature: _____ Signed Date: _____

As Trustee of the: _____
TRUST NAME

OR

Executor/Administrator Signature: _____ Signed Date: _____

Executor: _____ as Executor/Administrator of the Estate of: _____
EXECUTOR NAME DECEASED'S NAME

OR

Corporate Authorized Signature: _____ as _____
TITLE

Of _____ Signed Date: _____
COMAPANY NAME

OR

Attorney-in-Fact Signature: _____ Signed Date: _____

Power of Attorney: _____
PRINCIPAL NAME

TO ENSURE YOU RECEIVE YOUR BENEFIT PAYMENT PROMPTLY, PLEASE CHECK TO MAKE SURE YOU HAVE:

- Read and agreed to the certification of your taxpayer ID terms in Section 5
- Enclosed an original certified death certificate and other documentation, such as trust documents, power of attorney papers, or any other required forms
- Returned the original policy contract or checked the lost or destroyed box
- Signed and dated on the appropriate line in Section 7

PLEASE NOTE:

NO FAXED OR EMAILED DOCUMENTS WILL BE PROCESSED OR ACCEPTED.

Mailing address:
NSS Life
351 Valley Brook Road
McMurray, PA 15317-3337

Phone numbers:
724-731-0094
1-800-488-1890

Website:
www.nsslife.org