

Send Claim to:
 The United States Life Insurance Company
 In the City of New York
 Attn: Policy Benefits-Life/MSN 2-K
 3600 Route 66 • PO BOX 1580
 NEPTUNE, NJ 07754-1580

THE UNITED STATES LIFE Insurance Company In the City of New York
 Member of American International Group, Inc.

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 INSURANCE ACT, WHICH IS A CRIME.

TO AVOID UNNECESSARY DELAY IN PROCESSING CLAIMS, PLEASE COMPLETE ALL BLANK AREAS AND SIGN FORM.

STATEMENT OF POLICYHOLDER

NAME OF DECEASED EMPLOYEE		ADDRESS OF DECEASED EMPLOYEE		AMOUNT OF INSURANCE
GROUP POLICY NO.	CERTIFICATE NO.	NAME AND ADDRESS OF EMPLOYER		TELEPHONE NUMBER
DATE OF EMPLOYEE'S				
Birth	Death	Last day of full time active work for employer		
REASON FOR STOPPING WORK				
<input type="checkbox"/> Illness <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retirement <input type="checkbox"/> Lay Off <input type="checkbox"/> Other (Explain briefly)				
<input type="checkbox"/> Union Employee <input type="checkbox"/> Full Time		Average Number of Hours Worked Per Week		
<input type="checkbox"/> Non-Union Employee <input type="checkbox"/> Part Time				
IF DUE TO ILLNESS, DISABILITY BENEFITS WERE PAID				
From	To	Carrier's Name		
DURATION OF EMPLOYMENT		EMPLOYEE'S JOB TITLE	WEEKLY EARNINGS	INSURANCE CLASS
From	Through			
IF CONTRIBUTORY INSURANCE, TO WHAT DATE HAS EMPLOYEE'S CONTRIBUTION BEEN PAID?				
Date				
BENEFICIARY (IF ESTATE CERTIFIED COPY OF COURT ORDER APPOINTING EXECUTOR OR ADMINISTRATOR SHOULD BE ATTACHED)				
Name and Address		Relationship	Age	
GUARDIAN (IF BENEFICIARY IS A MINOR, A CERTIFIED COPY OF COURT ORDER APPOINTING GUARDIAN SHOULD BE ATTACHED)				
Full Name		Address		
SEND CHECK TO	CURRENT DATE	SIGNATURE OF POLICYHOLDER'S OFFICIAL REPRESENTATIVE		

ATTENDING PHYSICIAN'S STATEMENT

If Decedent Was Disabled More Than 31 Days Prior to Death, Please Have This Statement completed By The Physician Who Treated During This Disability.

FULL NAME OF DECEASED		DATE OF DEATH	AGE
PLACE OF DEATH	DATE OF FIRST VISIT	DATE OF LAST VISIT	
IMMEDIATE CAUSE OF DEATH		DURATION	
CONTRIBUTORY CAUSES OR COMPLICATIONS		DURATION	
DEATH RESULTED FROM:			
<input type="checkbox"/> Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
IF DUE TO ACCIDENT, SUICIDE, OR HOMICIDE, DESCRIBE BRIEFLY.			
Decedent was totally disabled and unable to perform work from		to	
I hereby certify that the above answers are true and complete to the best of my knowledge and belief.			
DATE	PRINT NAME		
TELEPHONE NUMBER	SIGNATURE		
	ADDRESS		

THE CERTIFICATE OF INSURANCE AND ORIGINAL ENROLLMENT CARD (IF AVAILABLE) SHOULD ACCOMPANY THIS FORM
 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

CLAIMANTS 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?

WHEN DID DECEASED FIRST CONSULT A PHYSICIAN
FOR HIS LAST ILLNESS?

Date

Date

WAS DEATH THE RESULT OF AN ACCIDENT?

DATE OF ACCIDENT

PLACE OF ACCIDENT

DID ACCIDENT OCCUR IN COURSE OF EMPLOYMENT?

Yes No

DESCRIBE ACCIDENT BRIEFLY

NAMES AND ADDRESSES OF ALL PHYSICIANS WHO ATTENDED THE DECEASED AND OF ALL HOSPITALS AND INSTITUTIONS WHERE HE WAS TREATED DURING THE LAST ILLNESS AND DURING FIVE YEARS PRIOR THERETO:

Name	Address	Date	Disease or Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FACTS CONCERNING OTHER LIFE, HEALTH AND ACCIDENT INSURANCE CARRIED BY DECEASED.

Company	Policy Number	Amount of Insurance
_____	_____	_____
_____	_____	_____
_____	_____	_____

ORIGINAL CERTIFICATE OF INSURANCE MUST BE RETURNED IF AVAILABLE.

Certificate enclosed Certificate cannot be located

IN WHAT CAPACITY DO YOU CLAIM THIS INSURANCE (IF ADMINISTRATOR, EXECUTOR OR GUARDIAN, ATTACH A COPY OF COURT ORDER APPOINTMENT)

YOUR DATE OF BIRTH

YOUR SOCIAL SECURITY NUMBER

ESTATE TAX I.D./TRUST TAX I.D. (PROVIDE IF CLAIM MADE BY ESTATE OR TRUST)

I elect to receive payment

- Immediate availability of funds from an interest-bearing checking account* with free check-writing privileges.
- at a later date while I decide whether I want the proceeds immediately or wish to elect a different settlement. If I do not inform you otherwise within one month, you will pay the proceeds to me immediately.*
- as a non-cash settlement option. (Please Specify and if necessary, contact your insurance plan administrator for a description of non-cash settlement options available)

* If your proceeds are eligible and exceed the current applicable minimum (\$5,000) set by the company, an interest-bearing checking account will be established in your name. You may immediately write a check for the full amount or leave your account open and draw money only as you need it. Meanwhile, the funds will earn interest at the variable rate currently effective for The United States Life Insurance Company Instant Access Accounts payable through State Street Bank and Trust Company. The Instant Access Account is not available to estates, trusts or guardianships.

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 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. A photostatic copy of this authorization shall be as valid as the original. Furthermore, in the event an Instant Access Account is opened, the Signature of Claimant(s) presented on this claim form will be used for signature verification.

Under penalty of perjury, I certify that the Social Security/Tax I.D. number provided on this form is true, correct, and complete. I understand that failure to furnish this number can subject me to back-up withholding. I certify that I am not now subject to back-up withholding.

DATE

PRINT CLAIMANT'S NAME

WITNESS

SIGNATURE OF CLAIMANT, WITH TITLE, IF ANY

ADDRESS

ADDRESS

ADDRESS

ADDRESS

ADDRESS

ADDRESS

DAYTIME TELEPHONE NUMBER