State Mutual
Insurance Company

PO Box 11864
Winston-Salem, NC 27116

Phone: 833-508-0404
Fax: 336-759-3141

Beneficiary Statement

Instructions: This form is to be completed by the beneficiary/claimant and sent along with the **policy** and a **certified certificate of death** to the address above.

Information About the Deceased

Please print all information on this form

Policy Number(s):			
Deceased's Full Name:		List any other names the insured was known by (maiden name etc):	Date of Death:
Deceased's Birth Date:	Deceased's Social Security No.	Place of Death (If hospital or institution, give name, otherwise exact location):	
City, County and State of Death:		Did death result from: ☐Natural? ☐Accident? ☐Homicide? ☐Suicide? If checked other than Natural, please forward copies of accident, police and/or coroner/medical examiner reports. Also enclose any pertinent newspaper articles.	

I HAVE (CHECK ONE):

☐Enclosed the **ORIGINAL POLICY** (or Certificate of Coverage), **OR** ☐Completed the following **LOST POLICY DECLARATION**

LOST POLICY DECLARATION

☐I certify that the above-referenced policy is lost or destroyed and I have no knowledge of its whereabouts.

I agree that if the original policy is found, after issuance of a Duplicate Policy, or Certificate of Coverage, the Duplicate Policy or Certificate of Coverage will be returned to the Company and in no event will it constitute a claim against the Company. I further agree that State Mutual Life Insurance Company shall and will be fully indemnified and held harmless against any and all claims, which may be made by reason of, or growing out of the original policy.

______________________________ Signature of Owner/Beneficiary

______________________________ Owner's/Beneficiary's Name Printed

Information About the Beneficiary (If the beneficiary is deceased, please attach a copy of the death certificate)

Beneficiary's Full Name:	Beneficiary's Relation to Insured:	Beneficiary's Date of Birth:
Beneficiary's Mailed Address (check will be mailed to this address):	Beneficiary's Phone:	
	Beneficiary's Social Security or Tax ID No.:	
In what capacity are you claiming the proceeds? ☐Individually (Beneficiary) ☐Executor of the Estate ☐Trustee ☐Other-explain	Have you assigned any of the proceeds? ☐No ☐Yes- if yes, give amount of assignment, name and address of assignee.	

Spousal Continuation (Continues Policy with spouse as owner / annuitant. Optional)

Type of plan:_______Non-Qualified _____Qualified (IRA, Keough, Pension, Profit Sharing, Deferred Comp., etc)

Acknowledgement and Release for Information

I hereby certify that the above information is both complete and true to the best of my knowledge and belief. I acknowledge that I have read the authorization for information below and fraud notice attached. If my funds will be deposited directly to a bank account, I acknowledge the receipt and satisfaction of the full amount owed for all claims on the referenced policy(s). The furnishing of forms by the Company does not constitute an admission that there is any insurance in force. **I authorize** all physicians, hospitals, clinics or any other person, to disclose any information acquired thereby and furnish all such information to State Mutual Insurance Company for the purpose of adjudicating this claim. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

Signed at (City, County, State):________________________________ on ____/____/____

Claimant Signature: ________________________________

Witness's Signature:________________________________(An unrelated adult person)

Witness's Printed Name: ________________________________

Fraud Notices

"I understand that some states require State Mutual Life Insurance Company to notify me that 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." **[Residents of AK, AZ, CA, CO, FL, KY, ME, MN, NE, NH, NJ, NM, NY, OH, OR, PA, PR, TN and WA, refer to the specific notices listed below.]**

Alaska, Arizona, Nebraska, New Hampshire and Oregon Residents: "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 may be guilty of a crime and may be subject to fines and confinement in prison."
California Residents: "For your protection California law requires the following notice 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 state prison."
Colorado Residents: "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.
Florida Residents: "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."
Kentucky, Ohio and Pennsylvania 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 subjects such person to criminal and civil penalties.
Maine, Tennessee and Washington Residents: "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."
Minnesota Residents: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."
New Jersey Residents: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."
New Mexico Residents: "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."_
Puerto Rico Residents: "Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor no more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

SPECIAL NOTICE TO ILLINOIS RESIDENTS:

Upon completion of the routine claim review and receipt of required documents, we will promptly review and evaluate the claim. A valid claim that is not paid within 31 days from the date we receive due proof of loss will include interest due and payable from the date of death at a rate of 10.0%.