



TheStandard®

Standard Insurance Company  
Life Benefits Department  
PO Box 2800 Portland OR 97208 888.609.9763 Tel

New Mexico Public Schools  
Insurance Authority  
Life Insurance Benefits  
Application Instructions

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**PLEASE READ CAREFULLY**

The application for life insurance benefits consists of the forms included in this packet, as well as the additional information noted under item 1 below. Please fill out every space on the Proof of Death form to avoid delays in our examination of your application for benefits. If a section does not apply, or information is not available, please write "NONE" in the space, so that we know you did not overlook the particular question. **If an incomplete form is received, it may be returned for completion.**

**1. Include the following information with the Proof of Death form.**

- Beneficiary Statement(s).  
*(See attached. If there is more than one beneficiary, please make a copy of the front and back of the statement.)*
- Certified death certificate.
- All copies of enrollment forms and change of beneficiary cards.
- For AD&D and Seat Belt claims, attach newspaper clippings, police or accident reports, and any other information available regarding the accident.

**2. Please have the beneficiary(ies) carefully read and complete the Beneficiary Statement which contains information about taxes.**

Please make sure all required forms are completed and returned to **NMPSIA, 410 Old Taos Highway, Santa Fe, New Mexico, 87501**. Examination of the claim will begin when all completed forms are received by The Standard. Should you have questions, The Standard is available to assist you. Please call **(888) 609-9763** or e-mail us at **lifebenefits@standard.com**.

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 Proof of Death Claim Form

*Forms may be returned for unanswered questions.*

Name of Deceased:				Effective Date of Member's Insurance:	
Social Security No.:				Date of Membership/Employment:	
Date of Birth:				Date member was last actively at work:	Had employment terminated prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
Date of Death:				Reason member ceased working: <input type="checkbox"/> Death <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain) _____	
If Dependent Claim, Name of Member:				Last month premium was paid for member or dependent:	
School Name and District No.:				Monthly or annual salary: \$	
Group Policy No.: <b>645549</b>				Date of last salary increase:	
Amount of insurance claimed: Basic Life \$ _____ Dependents Life \$ _____ Additional Life \$ _____ Other (specify) \$ _____ Accidental Death \$ _____				Salary prior to increase: \$	
				Usual number of hours employee worked per week:	
				Amount of monthly premium paid for the insured:	
Member also had the following claims with Standard Insurance Company: (check all that apply) <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Waiver of Premium				Member was: (check all that apply) <input type="checkbox"/> Full-time <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Part-time <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried <input type="checkbox"/> Commissioned <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Name of Beneficiary	Social Security No.	Relation	Date of Birth	Address*	Phone
<b>*If the mailing address is a PO Box, we must have a street address in addition to the PO Box mailing address.</b>					
Remarks:					
<p><b>In addition to this form, the following items are required:</b></p> <ul style="list-style-type: none"> <li>● Beneficiary Statement.</li> <li>● Copies of enrollment forms and any subsequent beneficiary changes.</li> <li>● Certified death certificate.</li> <li>● For AD&amp;D and Seat Belt Claims, newspaper clippings, police and accident reports, or other information regarding the accident.</li> </ul>					
<b>Acknowledgment</b>					
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.					
Signature of Benefit Administrator			Date	Name of Employer or Association	
Benefit Administrator's Name (Please print)			Street Address		
( ) Phone No.			City	State	Zip Code
<b>Payments paid via check will be sent directly to policyholder.</b>					

Some states require us to provide the following information to you:

**CALIFORNIA RESIDENTS**

For your protection, California law requires the following 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 the 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 RESIDENTS**

**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 RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**MARYLAND AND RHODE ISLAND RESIDENTS**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a 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.

**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 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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.

**ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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 Beneficiary Statement

**TAX INFORMATION**

Under the Federal Income Tax law, we are required to request that you (*as the payee*) provide Standard Insurance Company (*as payor*) with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with Federal Income Tax law.

**CERTIFICATION — Under Penalties Of Perjury, I Certify That:**

1. The number shown on this form is my correct Social Security/Taxpayer Identification Number (*or I am waiting for a number to be issued to me*), **and**
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.

**CERTIFICATION INSTRUCTIONS** — You must cross out item (2) if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

If you decide to assign a portion of your benefits to a funeral home, please include a notarized assignment form (*supplied by the funeral home*) and an itemized copy of the funeral bill. A separate check for the amount of the assignment will be delivered directly to the funeral home.

<b>Acknowledgement</b>			
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.			
Signature of Beneficiary ( <i>please use dark ink and sign as you would a check</i> )		Relationship to Deceased	
Name ( <i>please print</i> )		Date of Birth	
Social Security Number ( <i>required</i> )			
Mailing Address ( <i>if this is a PO Box, a street address is required</i> )		City	State Zip Code
Street Address ( <i>only if your mailing address is a PO Box</i> )		City	State Zip Code
Work Phone No.		Home Phone No.	

**THIS PORTION FOR USE BY STANDARD INSURANCE COMPANY ONLY**

Claim No.(s) _____	Policy No.(s) <b>645549</b>
Deposit Amount \$ _____	Division 037 Sub 107
Code 402 <input type="checkbox"/> 403 <input type="checkbox"/> 404 <input type="checkbox"/> 405 <input type="checkbox"/> 406 <input type="checkbox"/> 407 <input type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F
Transmittal Date _____	Authorized Signature _____

<b>Policyholder</b>	Name of Deceased: _____
<b>Use Only</b>	Group Policy No.: <b>645549</b>

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