



The Standard[®]

Standard Insurance Company
Life Benefits Department
800.628.8600 Tel 888.414.0389 Fax
PO Box 2800 Portland OR 97208

Wayne State University Board of Governors Life Insurance Benefits Proof of Death Claim Form

Please type or print. Forms may be returned for unanswered questions.

Name of Deceased:				Date of Membership/Employment:	
Social Security No.:				Date member was last actively at work:	
Date of Birth:				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:	
Group Policy No.:		Member Class:		Monthly or annual salary (N/A for retiree claims):	
648846				\$	
Amount of insurance claimed:				Date of last salary increase:	
Basic Life \$ _____ Dependents Life \$ _____					
Additional Life \$ _____				Salary prior to increase:	
Note: AD&D will automatically be reviewed if applicable.				\$	
Name of Beneficiary	Social Security No.	Relation	Date of Birth	Address*	Phone
*If the mailing address is a PO Box, we must have a street address in addition to the PO Box mailing address.					
Remarks:					
In addition to this form, the following items are required:					
● Original enrollment forms and any subsequent beneficiary changes.					
Acknowledgment					
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 2 of this form.					
Signature of Benefit Administrator			Date		
_____			_____		
Benefit Administrator's Name (Please print)			Wayne State University Board of Governors		
_____			Name of Employer or Association		
_____			Total Compensation and Wellness		
_____			5700 CASS Avenue, Suite 3638		
_____			Street Address		
(_____)		Detroit		MI	
Phone No.		City		State	
_____		_____		48202	
_____		_____		Zip Code	

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

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

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.