TheStandard®

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

Survivor Income Application Instructions

Your application for Survivor Income Benefits consists of the forms included in this packet and documents provided by you *(see below)*. Our examination of your application will begin when all the forms have been received. If an application is incomplete, it may be returned to you for completion.

Employer's Statement – Completed by the employer of the deceased member.

Applicant's Statement – Completed by the Surviving Spouse, Surviving Child or Estate Manager of the deceased.

1. **Include the following pertinent documents with your application for benefits:**
   - Certified copy of death certificate.
   - Enrollment forms for Survivor Income life insurance.
   - Marriage License.
   - Certifications, awards and determinations from other income or benefit sources available to Surviving Spouse and Surviving Children.
   - Proof of employment of Surviving Spouse and Surviving Children.
   - Birth certificates for each Surviving Child.
   - Proof of high school or university attendance for each Surviving Child 18 and older and still in school.
   - If Surviving Children were adopted by the deceased, provide a copy of adoption papers for each Surviving Adopted Child.

2. **Prior to submitting your application for benefits, please verify that:**
   - All forms have been completed, signed and dated.
   - You have included pertinent documents with your application.
   - You have saved copies of your completed documents for future reference.

3. **Submit your completed application to the address listed at the top of this form.**

If you have questions, our office is available to assist you. Please call 800.628.8600 or e-mail us at lifebenefits@standard.com.

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Survivor Income Employer's Statement

EMPLOYEE INFORMATION

1. Name of Employee:		2. Date of Employment:
3. Date insurance became effective:	4. Was employee insured at date of death? ☐ Yes ☐ No	5. Date last worked and reason they stopped:
6. Basic monthly earnings on date last worked:	7. Date of last salary increase:	8. Earnings prior to last increase:
9. Job status when death occurred (check all that apply): ☐ Full-time ☐ Part-time ☐ Permanent ☐ Seasonal ☐ Terminated ☐ Laid-off ☐ On leave ☐ On call		10. Number of hours worked per week:

OTHER INCOME OR BENEFITS

If the deceased member, spouse and/or children are entitled to receive other income or benefits, please list all sources.

Name of recipient	Source of income or benefit	Amount of total income or benefit	Monthly amount	Date entitled to receive income or benefit
	Employer			
	Social Security			
	Workers' Compensation			
	City, State, Federal, Government Disability or Retirement			
	Group Insurance			
	Individual Insurance			
	Pension Plan			

Acknowledgement

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 notices on page 3 of this form.

Signature of Benefit Administrator: _____ Date: _____

Name of Benefit Administrator: _____ Phone No.: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address *(if different):* _____ City: _____ State: _____ Zip Code: _____

Employer's Name: _____

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.

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 a 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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Survivor Income Applicant's Statement

SURVIVING SPOUSE

Deceased's Name: _____

Attachments to application:

Deceased's Employer: _____

- Copy of Marriage License.
- Copy of Check Voucher, if Surviving Spouse is employed.

Name of Surviving Spouse:		Social Security No.:		Date of Birth:
Date of Marriage:	Work Phone No.:		Home Phone No.:	
Address:		City:	State:	Zip Code:
Is Surviving Spouse currently employed? ☐ Yes ☐ No *(If yes, please complete employment information below.)*		If no, does Surviving Spouse plan on working in the future? ☐ Yes ☐ No		
Name of Surviving Spouse's Employer:		Monthly Salary of Surviving Spouse:		
Surviving Spouse Supervisor's Name:		Supervisor's Phone No.:		
Employer's Address:		City:	State:	Zip Code:

SURVIVING CHILDREN

Attachments to application:

- Copy of birth certificate for each Surviving Child.
- Proof of high school or university attendance for each Surviving Child that is over the age of 18 and attending school.
- If Surviving Children were adopted by the deceased, provide copies of adoption papers for each Adopted Child.

If more space is needed to list additional surviving children and their employment histories, please use a blank sheet of paper.

Name(s)	Social Security Number(s)	Date(s) of Birth
1)		
2)		
3)		
Are any surviving children working full or part-time? ☐ Yes ☐ No *(If yes, please complete employment information listed below.)*		

1) Surviving Child

Name of Surviving Child:	Phone No.:		Monthly Earnings:
Employer's Name:	Employer's Phone No.:		
Address:	City:	State:	Zip Code:

2) Surviving Child

Name of Surviving Child:	Phone No.:		Monthly Earnings:
Employer's Name:	Employer's Phone No.:		
Address:	City:	State:	Zip Code:

3) Surviving Child

Name of Surviving Child:	Phone No.:		Monthly Earnings:
Employer's Name:	Employer's Phone No.:		
Address:	City:	State:	Zip Code:

OTHER INCOME OR BENEFITS

Attachments to application:

- If the deceased member, spouse and/or children are entitled to receive other income or benefits, please list all sources and submit copies of certifications, awards and determinations with this application.

Name of recipient	Source of income or benefit	Amount of total income or benefit	Monthly amount	Date entitled to receive income or benefit
	Employer			
	Social Security			
	Workers' Compensation			
	City, State, Federal, Government Disability or Retirement			
	Group Insurance			
	Individual Insurance			
	Pension Plan			

Acknowledgement

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 notices on page 6 of this form.

Name *(please print):* _____

Signature: _____ Date: _____

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