



Health & Welfare Benefit Systems, Inc.  
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## DEATH CLAIM FORM

Policies under which payment is requested:

Insured's Name Including Middle Initial:		Birth Date of Insured: / /		Place of Birth:	
Insured's Address (street, city, state, zip):					
Principle Cause of Death:		Date of Death: / /		Place of Death:	
				When did the health of the insured first begin to be affected? / /	
Are you the beneficiary named in the policy? In no, in what capacity do you request payment. <input type="checkbox"/> YES <input type="checkbox"/> NO			If payable to a trust, name and date of trust. Name: Date: / /		
Information on all Beneficiaries both living and deceased.					
Name If name differs from our records state old and new name.		Social Security# or Taxpayer ID#		Date of Birth or Date of Death	
				/ /	
Share of Proceeds (%)					
Payment Options:					
<ul style="list-style-type: none"> <li>• Pay part of all of the proceeds into an Interest, Installment, or Life Option.</li> <li>• Pay all proceeds immediately. If proceeds equal \$5,000 or more and meet the other eligibility requirements, they will be placed in an interest bearing checking account.</li> </ul>					
Signatures: Each beneficiary must complete and sign required Beneficiary Information section below.					
<b>REQUIRED BENEFICIARY INFORMATION – THIS SECTION MUST BE COMPLETED IN FULL</b>					
Beneficiary's Full Name: Address (city, state and zip code):					
If the taxpayer ID# or Social Security Number is not supplied, the policy must be subject to federal and state withholdings. Under the penalties of perjury, I certify that the information on this form is true, correct and complete and that I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.					
Signature:			Date: / /		
<b>REQUIRED BENEFICIARY INFORMATION – THIS SECTION MUST BE COMPLETED IN FULL</b>					
Beneficiary's Full Name: Address (city, state and zip code):					
If the taxpayer ID# or Social Security Number is not supplied, the policy must be subject to federal and state withholdings. Under the penalties of perjury, I certify that the information on this form is true, correct and complete and that I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.					
Signature:			Date: / /		