IRON WORKERS'
Tri-State Welfare Fund

18861 90th Ave, Suite A
Mokena, Illinois 60448
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NOTICE OF DEATH

THE UNION LABOR LIFE INSURANCE COMPANY is hereby notified that:

Social Security Number: _____

_____, who is insured
Name of Insured

under _____ _____
Name of Policyholder Policy Number

*C-_____ _____ died on _____.
Policy Number Certificate Number Date

Life Insurance Amount $_____

* Accidental Death/Dismemberment Amount $_____

Dated at: day of 20

State of Residence

By: _____
Office Title

* To be completed if filing for Accidental Death/Dismemberment
This form should be forwarded as soon as the Policyholder receives notice of death, to:

The Union Labor Life Insurance Company
111 Massachusetts Avenue, N.W.
Washington, D.C. 20001

The Union Labor Life Insurance Company
Proof of Death

Claim is hereby filed for the following benefits and amounts.
Name: _____
Death Claim: Amount $_____
Cert #)_____ Policy No. G-_____
Accidental Death Claims: $_____
Cert #)_____ Policy No. G-_____

POLICYHOLDER CERTIFICATION
We certify that the decedent was eligible at the time of death.
Policyholder: _____
(Name of Union, Welfare Fund, or Employer)
By: _____
(Signature and Title)

BENEFICIARY STATEMENT

REGARDING THE INSURED:

1. Social Security Number _____
   a. Birth Date: _____ (Month Day Year)
   b. Birthplace: _____ (City State)

Date: _____
2. a. Date of Death: _____ (Month Day Year)
   b. Place of Death: _____ (City State)

3. a. Date last worked: _____
   b. Last occupation: _____

Last Employer:
   c. Name: _____
   d. Address: _____

4. a. Duration of illness since last worked. _____
   b. how long was insured away from work during this illness? _____

Cause of Death — (Details, please)
c. _____
_____

5. Attending Physician:
   a. Name: _____
   b. Address: _____

6. Had the Insured other life insurance? ❑ Yes ❑ No
If so, list insuring companies and amounts below:
_____ $_____
_____ $_____
_____ $_____

QUESTION NO. 7, 8, AND 9 SHOULD ONLY BE ANSWERED IF ACCIDENTAL DEATH CLAIM IS FILED.

7. a. Date of Accident: _____ (Month Day Year)
   b. Place of Accident: _____

8. Did the alleged accidental death of the Insured arise out of, or in the course of employment?
_____

9. a. Describe fully how the accident occurred and the nature of injuries received:

REGARDING BENEFICIARY: * BENEFICIARY SOCIAL SECURITY NO. MUST BE PROVIDE FOR INTEREST PAYMENT

10. a. Name: _____
    b. Full P.O. Address:
    _____
    _____
    _____
    c. Birth Date: _____ (Month Day Year)

d. Are you the beneficiary named in the certificate?
_____
e. If not the beneficiary,
   1. What expenses have you incurred in behalf of the insured or for his/her burial?
   _____
   2. By what right do you claim the Insurance Proceeds?_____

Where several beneficiaries have been named, please follow instructions on next page.
Date at: _____ on _____
Beneficiary _____
Social Security No. _____

Beneficiary _____
Social Security No. _____

Note: See instructions on next page.

INSTRUCTIONS

1. PLEASE MAKE CERTAIN THAT ALL PERTINENT QUESTIONS ARE ANSWERED AND THE PROPER SUPPORTING DOCUMENTS ARE INCLUDED BEFORE FORWARDING CLAIM IN ORDER TO AVOID UNNECESSARY DELAY IN PROCESSING THE CLAIM.

2. A certified copy of the official death certificate should be attached.

3. The group insurance certificate of the deceased should be attached. If not available, statement of Loss of Group Certificate (**Form #LC.A. 22.1263**) should be completed by the beneficiary and forwarded with claim together with the insured's enrollment card.

4. If any insurance is to be paid to a minor beneficiary, a certified copy of the appointment of a guardian of the estate of the minor by the Court is required before any payment is made.

5. If any insurance is to be paid to the estate of the deceased insured, a certified copy of the appointment of the executor or administrator of the estate of the deceased insured by the Court is required before any payment is made.

6. If the designated beneficiary predeceased the insured, a certified copy of the death certificate of the deceased beneficiary will be required.

7. If no beneficiary was designated or if the designated beneficiary predeceased the insured, then the insurance become payable to the first surviving class of the following classes the successive preference beneficiaries: (1) The spouse of the deceased insured, (2) the child or children of the deceased insured, (3) the parents of the deceased insured, (4) the brothers and sisters of the deceased insured, (5) the executor or administrator of the estate of the deceased insured. *Note: If the insurance is to be paid under this provision, an affidavit from the claimant on **Form No. LC.A. 17.263** will be required specifying the basis on which the claimant is presenting claim as a preference beneficiary.*

8. If more than one beneficiary is entitled to receive the insurance proceeds, the additional beneficiaries should sign below and provide the requisite information.

9. If the decedent was permanently and totally disabled and his death occurred more than 31 days after the termination of his insurance under the group policy, the beneficiary should complete and have the decedent's attending physician complete **Form No. 1182.4A**, which should be forwarded with the claim.

NAME AND ADDRESS OF ADDITIONAL BENEFICIARIES	DATE OF BIRTH	SIGNATURE