



# IRON WORKERS'

## Tri-State Welfare Fund

333 Pierce Road, Suite 410  
 Itasca, Illinois 60143  
 Toll-Free 866-463-9418  
 Fax 630-967-3080  
[www.tristatewelfarefund.com](http://www.tristatewelfarefund.com)  
 tristate@abpa-tpa.com

### NOTICE OF DEATH

THE UNION LABOR LIFE INSURANCE COMPANY is hereby notified that:

Social Security Number: \_\_\_\_\_

\_\_\_\_\_, who is insured under  
 Name of Insured

_____ Name of Policyholder	_____ Policy Number	_____ died on _____
*C-_____ 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

3. a. Date last worked: \_\_\_\_\_

b. Last occupation: \_\_\_\_\_

4. a. Duration of illness since last worked. \_\_\_\_\_

b. how long was insured away from work during this illness? \_\_\_\_\_

5. Attending Physician:

a. Name: \_\_\_\_\_

b. Address: \_\_\_\_\_

Date: \_\_\_\_\_

2. a. Date of Death: \_\_\_\_\_  
Month Day Year

b. Place of Death: \_\_\_\_\_  
City State

Last Employer:

c. Name: \_\_\_\_\_

d. Address: \_\_\_\_\_

Cause of Death — (Details, please)

c. \_\_\_\_\_

\_\_\_\_\_

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