WESTCHESTER HEAVY CONSTRUCTION LABORERS HEALTH AND WELFARE FUND
LOCAL No. 60
140 BROADWAY
HAWTHORNE, NY 10532
(914) 769-2440

Proof of Death

INSTRUCTIONS FOR FURNISHING PROOF OF DEATH

1. Beneficiary or other claimant should complete Part II. Attach certified copy of deceased's Death Certificate and return to Group Administrator for completion of Part I.

2. If any beneficiary, other than a contingent beneficiary, died before the Insured, a copy of the Certificate of Death of such beneficiary must be attached to the proofs. In such case, claim should be made by the other beneficiaries or, if there be none, by the duly appointed representative of the Insured's estate.

3. If claim is made on behalf of the estate of the deceased, a certified copy of the Letters of Administration must be attached to the proofs.

4. If any beneficiary is a minor or legally incompetent, a certified copy of the appointment of a guardian must be attached to the proofs.

FOR BENEFITS OFFICE USE ONLY

Social Security # ______________________ Claim No. __________ Amount $ __________

Name of Insured ____

Group Administrator: Westchester Heavy Construction Laborers Local 60 Health & Welfare Fund, 140 Broadway, Hawthorne, NY 10532

Address: ____

Approved ______________ 19 ______ Amount $ __________

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PART I

STATEMENT OF GROUP ADMINISTRATOR

1. Full name of deceased ______________________ Soc. Sec. # ______________________

2. Date employment commenced ____________ Occupation at time of death ______________________

3. Date of last active work ____________ If retired, date of retirement ______________________

4. If date deceased last worked was more than 31 days prior to death, was deceased:
   Totally disabled ☐ On leave of absence ☐ On temporary layoff ☐

5. Name of beneficiary shown on your records ______________________ Relationship ____________

We hereby certify that, to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death for the amount of $____________.

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Name of Group Administrator

Date ______________________ By ______________________

Title ______________________

PART II

STATEMENT OF BENEFICIARY OR OTHER CLAIMANT

1. Full name of deceased ______________________

2. Last legal residence of deceased ______________________
   STREET CITY OR TOWN STATE ZIP CODE

3. Date of birth of deceased ______________________ Date of death ______________________

4. Cause and circumstances of death ______________________

5. Are you, the beneficiary, named in the certificate and entitled to the insurance proceeds? ____________

6. Your relationship to Insured ______________________ Your date of birth ____________

7. Your address ______________________
   STREET CITY OR TOWN STATE ZIP CODE

8. If you are not the named beneficiary, in what capacity do you make this claim? ____________

NOTICE: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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." (PURSUANT TO 11 NYC RR86)

I hereby certify that, to the best of my knowledge and belief, the above statements and answers are true.

Date ______________________

Claimant(s) Signature and Social Security Number

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Witness