

Northwest Plumbing and Pipefitting Industry Health and Welfare Fund

PHYSICAL: 7525 SE 24TH ST, SUITE 200, MERCER ISLAND, WA 98040 • MAILING: P.O. BOX 34203 • SEATTLE, WA 98124-1203 • (206) 441-7574
Administered by Welfare and Pension Administration Service, Inc.

MEMBER PROOF OF DEATH

The furnishing of this form is not an admission of liability by this Trust nor a waiver of any of its rights or defenses.

A "CERTIFIED COPY" OF DEATH CERTIFICATE MUST ACCOMPANY THIS FORM

Part I INFORMATION ABOUT THE MEMBER

Deceased Member's Name _____

Address _____
Street City State Zip

Date of birth _____ Social Security No. _____

Date of death _____

Are you making claim to Accidental Death Benefits provided under this Plan Yes No

If yes, please send us any newspaper articles, accident reports, or other documentations that would provide us with information about the death. (A separate "Application for Accidental Death Benefit" form will also be sent to you for completion.)

Was Member insured under any other policies? Yes No

Part II INFORMATION ABOUT THE BENEFICIARY

Your Name _____ Date of Birth _____

Address _____
Street City State Zip

Your phone number () _____ () _____
Area Code Home Number Area Code Work Number

You are making claim to:

- All of the proceeds on the Member's claim.
 Only the portion due me as one of the Beneficiaries of the Member.

Your relationship to Member:

- Spouse Child Other, explain

(over)

Part III REQUEST FOR TAXPAYER'S SOCIAL SECURITY NUMBER OR TAX IDENTIFICATION AND CERTIFICATION

If the Social Security Number or Tax Identification Number of the beneficiary is not supplied, the beneficiary may be subject to federal and state tax withholding. I have provided the appropriate Social Security or Tax Identification Number below:

- The benefits are being claimed by me as a beneficiary and my Social Security Number is _____
- The benefits are being claimed by the legal guardian of a minor/incompetent person's estate. The minor/incompetent person's Social Security Number is _____
- The benefits are being claimed by a trustee of a trust or a personal representative of an estate. The Tax Identification Number for the trust or estate is _____

The information provided by me on this claim form is true and complete to the best of my knowledge. Under penalty of perjury I certify that the Social Security Number or Tax Identification Number supplied on this form is true, correct, and complete.

Signature of Beneficiary Date

Part IV INSTRUCTIONS TO BENEFICIARY

The following information may help you.

More than One Beneficiary - If more than one beneficiary is named each beneficiary will need to complete a form.

Member's estate as Beneficiary - If the estate of the Member is named as beneficiary or the policy provides that benefits would be payable to the estate, Part II and Part III of the form must be completed by the executor or administrator of the estate. Certification from the clerk showing the appointment and qualification of the executor or administrator must be submitted.

Minor/Incompetent Beneficiary - If the beneficiary is a minor/incompetent person, Part II and Part III must be completed by the guardian of the minor/incompetent person's *estate*, and a certificate from the clerk of court, showing the appointment and qualification of the guardian of the minor/incompetent person's estate, must be submitted.

Predeceased Beneficiary - If the beneficiary of a Member dies prior to the Member, a standard certificate of death of the beneficiary must be submitted.

Additional Information - The company reserves the right to require and obtain such statements, authorizations and other information as it deems necessary to determine what benefits are payable on any claim.

Part V ADMINISTRATION CERTIFICATION

We hereby certify that, to the best of our knowledge and belief, the following statements and answers are true:

- 1. Name of Member _____ Member's Soc. Sec. # _____
- 2. Amount of life insurance _____ Was Member's insurance in force at time of dependent's death? _____
- 3. Give last date of which premium was paid _____

Date _____ By _____

RETURN THE COMPLETED FORM AND DEATH CERTIFICATE TO THE PLAN ADMINISTRATOR