



**THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA**

**PROOF OF DEATH**

600 Northern Blvd, Great Neck, NY 11021

**CLAIMANT SECTION**

If the Life Insurance is payable to an estate, executor, administrator, minor, or trust, or if a primary beneficiary is assigned contact The First Rehabilitation Life Insurance Company of America at 516-829-8100.

1. Policyholder/ Employer Name		2. Policy Number		
3. Deceased's Name	4. Date of Birth	5. Deceased's Place of Birth	6. Deceased's Social Security No.	
7. Deceased's address	City	State	Zip	8. Cause of death
9. Claimant's relationship to deceased	10. Do you claim this insurance as beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. If "No" in what capacity do you make this claim?		
12. Claimant's Full Name (Please Print)	13. Claimant's Social Security or Tax I.D #	14. Claimant's Date of Birth	15. Claimant's Tel No.	
16. Claimant's address	City	State	Zip	

Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number ( or that I am waiting for a number to be issued to me), and that I am not subject to backup withholding, either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or because that IRS has notified me that I am no longer subject to backup withholding. (If you do not give us your valid Social Security or Tax ID Number, the IRS may require us to withhold 31% of the interest payment made to you.)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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. In New York the person shall be subject to a civil penalty not to exceed five thousands dollars and the stated value of the claim for each such violation.

Signature of Claimant \_\_\_\_\_ Date \_\_\_\_\_  
**EMPLOYER SECTION** Please enclose employee's original Enrollment Form and all beneficiary designations.

1. Policyholder/ Employer's address		City	State	Zip	2. Telephone Number ( )	
3. If branch or affiliate, name and relationship to parent company						
4. Employee's Name	5. Social Security No.	6. Job title at time last worked		7. Certificate No.	8. Insurance Class	
9. Annual salary excluding bonus, overtime and special compensation on the redetermination date of your policy \$ _____	10. Amount of Insurance \$ _____	11. Date last worked full time ____/____/____		12. Schedule at time last worked ____ Hours per day ____ Days per week		
13. Date of Death ____/____/____	14. Date employee's insurance effective ____/____/____	15. Date of employment ____/____/____	16. Date employment terminated ____/____/____			

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17. If employment ended before death

Dismissed    Leave of Absence    Disability    Resigned    Retired    Layoff    \_\_\_\_\_

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18. I certify that the employee named above has been a full-time, active employee for whom premiums have been paid.

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Authorized signature and title

Date

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**PHYSICIAN SECTION**

Please attach certified copy of the Death Certificate. We reserve the right to require a Physician's Statement if it is necessary for a proper consideration of the claim.

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1. Deceased Name	2. Age	3. Address	City	State	Zip
4. How long have you known deceased?	5. Date of first attendance in last illness	6. Date of final attendance	7. Date of Death	8. Place of Death	
	____/____/____	____/____/____	____/____/____		

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9 Cause of death: Disease or condition directly leading to death (disease, injury, or complication which caused death, not mode of dying such as heart attack, asthenia, etc.)

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10. Morbid conditions giving rise to the above cause of death.

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11. Other significant conditions contributing to but not causing death.

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12. If death was due to suicide, homicide, or accident, state which and described briefly.

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13. Was there an inquest?    Yes    No   If "Yes" Please give results.

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14. Was there an autopsy?    Yes    No   If "Yes" please give results.

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15. Did deceased receive treatment during the past three years from another physician?  Yes    No   If "Yes" please give :

<u>Condition</u>	<u>Dates</u>	<u>Duration</u>	<u>Results</u>
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16. Physician's address	City	State	Zip	17. Telephone number
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18. Physician's Signature

Date