



The Standard®

Standard Insurance Company  
Life Benefits Department  
PO Box 2800 Portland OR 97208 800.628.8600 Tel

State of Ohio  
Exempt Employees  
Life Insurance Benefits  
Application Instructions

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**PLEASE READ CAREFULLY**

The application for life insurance benefits consists of the forms included in this packet, as well as the additional information noted under item 1 below. Please fill out every space on the Proof of Death form to avoid delays in our examination of your application for benefits. If a section does not apply, or information is not available, please write "NONE" in the space, so that we know you did not overlook the particular question. **If an incomplete form is received, it may be returned for completion.**

**Include the following information with the Proof of Death form.**

- Certified death certificate.
- For AD&D and Seat Belt claims, attach newspaper clippings, police or accident reports, and any other information available regarding the accident.

Please make sure all required forms are completed and returned to our office. Our examination of the claim will begin when all completed forms are received. Should you have questions, our office is available to assist you. Please call **(800) 628-8600** or e-mail us at **lifebenefits@standard.com**.

*Forms may be returned for unanswered questions.*

Name of Deceased:	Effective Date of Member's Insurance:		
Social Security No.:	Date of Membership/Employment:		
Date of Birth:	Date member was last actively at work:		
Date of Death:	Had employment terminated prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		
Last month premium was paid for member:	Reason member ceased working: <input type="checkbox"/> Death <input type="checkbox"/> Illness <input type="checkbox"/> Other (explain) _____		
Group Policy No.: <b>645571</b>	Annual salary: \$		
Occupation:	Date of last salary increase:		
Amount of insurance claimed: Basic Life \$ _____ Accidental Death \$ _____	Salary prior to increase: \$		
Member was: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Firefighter in Adjutant General's Office			
<b>Name of Person Reporting Death</b>	<b>Relation</b>	<b>Address</b>	<b>Phone</b>
Remarks: <b>The benefit amount is determined as follows and rounded to the next highest thousand if not already a multiple of a thousand:</b> <b>For part-time employees: 1040 hours X hourly rate</b> <b>For full-time employees: 2080 hours X hourly rate</b> <b>For Firefighters in the Adjutant General's Office: 2704 hours X hourly rate</b> <b>* For employees working less than 1040 hours per year, benefit will be calculated based on 1040 hours per year.</b>			
In addition to this form, the following items are required: <ul style="list-style-type: none"> <li>● Certified death certificate.</li> <li>● For AD&amp;D and Seat Belt Claims, newspaper clippings, police and accident reports, or other information regarding the accident.</li> </ul>			
<b>Acknowledgment</b>			
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.			
_____ Signature of Benefit Administrator	_____ Date	_____ Name of Employer or Association	
_____ Benefit Administrator's Name (Please print)		_____ Benefits Department, 30 E. Broad Street, 28th Floor	
_____ Phone No.		_____ City	_____ State
		_____ 43215	_____ Zip Code
<b>Payments paid via SSA will be sent directly to the beneficiary, unless requested otherwise.</b>			

Some states require us to provide the following information to you:

**CALIFORNIA RESIDENTS**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO RESIDENTS**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**FLORIDA RESIDENTS**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

**NEW JERSEY RESIDENTS**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW YORK RESIDENTS**

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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**PENNSYLVANIA RESIDENTS**

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 and subjects such person to criminal and civil penalties.

**ALL OTHER RESIDENTS**

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.