AARP® | Life Insurance Program from NEW YORK LIFE

Mail to:
PO Box 30713
Tampa FL 33630-3713

Claim Form

Please type or print legibly

1. List below only the Contracts under which you are making a claim

Insurance Contract Number(s):

2. Deceased Insured Information

Name of Deceased *First Middle Last*	Nickname or Maiden Name
Birthdate of Deceased:	Deceased's Date of Death:

Manner of Death: ☐ Natural ☐ Accident* ☐ Unknown ☐ Suicide* ☐ Homicide* ☐ Other

* Please attach copies of police and coroner's report and any relevant news articles.

3. Beneficiary Information

Beneficiary Name: *First Middle Last*

Mailing Address of Beneficiary: *Street City State Zip*

Relationship to the Deceased: ☐ Spouse ☐ Child ☐ Grandchild ☐ Parent ☐ Other_____

Birthdate of Beneficiary:	Home Phone - -
E-Mail Address of Beneficiary:	Alternate Phone - -

☐ **Individual Beneficiary:** If you request benefits to be paid to the funeral home, a copy of the assignment is required.

☐ **Minors:** If a legal guardian of the child's estate/property has been appointed by the court, he or she must sign on behalf of the minor child and submit a copy of the guardianship papers. If signing under the UTMA/UGMA, please sign your name and indicate your relationship (father, mother, etc) to the minor child as "Custodian of (name of child) under the (name of resident state) UTMA/UGMA.

☐ **Corporation:** Claim Form must be signed by Corporate Officer(s) and must indicate the title by which you are authorized to act on behalf of the company.

☐ **Estate:** Be sure to submit a copy of the certified appointment papers and provide Estate Tax ID below. Claim Form must be signed by an Estate Representative.

☐ **Trust:** A copy of the Title, Signature and Notary pages of the Trust are required, including the pages showing the Trustee and Successor Trustee. Provide Trust Tax ID below. Claim Form must be signed by a named Trustee.

☐ **Collateral Assignee:** A copy of the assignee's statement of interest must be provided. Claim Form must be signed by the assignee or their authorized representative.

Enter your Social Security Number if you are an individual beneficiary	Social Security Number - -	Enter Taxpayer Identification Number if claiming benefits as an Estate, Trust or Corporation	Taxpayer Identification Number -

Check **only** if statement below applies:

☐ I have been notified by the Internal Revenue Service that I am subject to back-up withholding as a result of failure to report all interest or dividends.

4. Beneficiary's Signature

I have read and understand the Fraud Statement that is applicable to the state in which I reside. **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.

- **I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and Back-up Withholding status information in Section 3 are correct. I also certify that I am a U.S. person, including a U.S. resident alien (non-US person must complete form W8-BEN).**
- **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid back-up withholding.**

Signature (REQUIRED) *Date*

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Survivorship Affidavit - Insured

If no estate has been established for the insured

Name of Deceased _____ Contract Number _____

Deceased's Social Security Number _____ Date of Death _____

INSTRUCTIONS: If the insured did not name a beneficiary or if a named beneficiary did not survive the insured by 15 days,

A. Provide New York Life Insurance Company with a certified death certificate for any named beneficiary.
B. Have this form completed by the first of the following surviving family members: (1) spouse, (2) son or daughter, or (3) parents.
C. If there is no surviving spouse, please indicate this and list the names and address of any surviving children. If there are no surviving children, please indicate this and list the names and address of the decedent's surviving parents. If there are no surviving parents, please indicate this and list the names and addresses of the decedent's surviving siblings.

Did the insured leave a surviving spouse at time of death? Yes ☐ No ☐

Full Name of Spouse (If Living) **Social Security #** **Address** **Date of Birth**

_____

Were any children of the insured (excluding step-children) living at time of death? Yes ☐ No ☐

Full Name of Each Child (If Living) **Social Security #** **Address** **Date of Birth**

_____

_____

_____

_____

Were the parents of the insured living at time of death? Yes ☐ No ☐

Full Name of mother and father (If Living) **Social Security #** **Address** **Date of Birth**

_____

_____

Were any siblings of the insured living at time of death? Yes ☐ No ☐

Full Name of siblings (If Living) **Social Security #** **Address** **Date of Birth**

_____

(Attach a separate sheet of paper if necessary. Any additional documentation must be signed, dated and witnessed)

I, _____ represent that, to the best of my knowledge, all statements on this affidavit are true and complete. I make this affidavit for the purpose of inducing New York Life Insurance Company to pay the proceeds of the life insurance under said Contract in accordance with its terms and conditions.

Signature _____ **Date** _____

Witness _____ **Date** _____