

**CLAIMANT'S STATEMENT**  
Relative to Death Benefit under Pipeline Industry Benefit Fund

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**BENEFICIARY OF DECEASED**

Give **YOUR** full name and address. (If you are the widow of deceased, give your maiden name, also.)

Name \_\_\_\_\_ SSI # \_\_\_\_\_  
Street and Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Complete as much of the following information as you can.

Name of Deceased \_\_\_\_\_ S. S. # \_\_\_\_\_  
Last Name First Name Middle Name

Date of Birth \_\_\_\_\_ Cause of Death \_\_\_\_\_

Place of Birth \_\_\_\_\_ When did health of deceased first become impaired? \_\_\_\_\_

Date of Death \_\_\_\_\_ In last illness when did deceased first consult a physician? \_\_\_\_\_

Place of Death \_\_\_\_\_ On what date did deceased last attend usual work? \_\_\_\_\_

List all physicians who attended or prescribed for deceased during illness which resulted in death.

Name	Address
_____	_____
_____	_____
_____	_____

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**DECLARATION**

I hereby make claim to said death benefit as beneficiary and agree that the written statements and affidavits of all physicians who attended or treated the deceased and all other papers called for by the instructions hereon shall constitute and they are hereby made a part of all these Proofs of Death, and further agree that the furnishing of this form or any of the forms supplemental thereto by the Trustees shall not constitute nor be considered an admission by them that there was any death benefit in force of the life in question nor a waiver of any of the rights or defenses of the Trustees or of the Fund.

I expressly waive on behalf of myself and any other party who shall have or claim any interest in the Pipeline Industry Benefit Fund with respect to the deceased, all provisions of law forbidding any physician or any other person who attended or examined the deceased, or any hospital (including Veterans' Hospital) or sanitarium in which deceased was confined, treated, or examined, from disclosing any information or knowledge acquired thereby and I authorize the furnishing of all such information to the Trustees. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Claimant's Signature \_\_\_\_\_ Age \_\_\_\_\_ Relation to Deceased \_\_\_\_\_

Date \_\_\_\_\_ First Witness to Signature \_\_\_\_\_ Second Witness to Signature \_\_\_\_\_

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See back of sheet for instructions and further information to be furnished.

IT IS NOT NECESSARY TO EMPLOY ANY PERSON NOR INCUR ANY EXPENSE  
TO COLLECT A VALID CLAIM FROM THE BENEFIT FUND

## **INSTRUCTIONS**

The claim must be made by the party or parties to whom the death benefit is payable as beneficiaries. If there is more than one beneficiary, each beneficiary should make a separate statement. When the benefit is payable to a minor, claimant's statement must be made by the guardian, a certified copy of whose appointment and authority must be furnished.

When the benefit is payable to estate or legal representative of the Member, either by specific designation or failure to designate some other beneficiary, a claimant's statement must be made by the executor or administrator, a certified copy of whose appointment and authority must be furnished.

If any named beneficiary predeceased the Member, unless the current beneficiary designation by the Member specifically provides otherwise, claimant's statement should be made by the duly appointed executor or administrator of the Member's estate, copy of whose appointment and authority should be furnished. Also a certified copy of the death certificate of the deceased beneficiary is required.

The signature of each claimant must be witnessed by two persons.

In addition to the Claimant's Statement, please furnish:

- Attending Physician's Statement
- Certified Copy of Death Certificate, or
- Mortician's Statement
- Newspaper write-up

When a coroner's inquest or investigation has been held, a copy of the evidence and verdict, duly certified must accompany physician's statement.