WESTCHESTER PUTNAM COUNTIES HEAVY & HIGHWAY LABORERS
BENEFIT FUNDS
PENSION - WELFARE -ANNUITY- LEGAL-TRAINING

LOCAL 60

Union Trustees
Anthony Ascencao
Michael Moreira
Jacinto Fragoso

140 BROADWAY
HAWTHORNE, N.Y.10532
Tel: (914} 769-2440
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Employer Trustees
John Cooney Jr.
George Pacchiana

Proof of Death

INSTRUCTIONS FOR FURNISHING PROOF OF DEATH

1. Beneficiary or other claimant should complete part II. Attach certified copy of deceased's Death Certificate and return to Group Administrator for completion of part I.
2. If any beneficiary, other than a contingent beneficiary must be attached to the proofs. In such case, claim should be made by the other beneficiaries or if there be none, by the duly appointed representative of the lnsured's estate.
3. If claim is made on behalf of the estate of the deceased, a certified copy of the Letters of Administration must be attached to the proofs.
4. If any beneficiary is a minor or legally incompetent, a certified copy of the appointment of a guardian must be attached to the proofs.

FOR BENEFITS OFFICE USE ONLY	
Social Security #	Amount:$
Name of Insured:	
Group Administrator:	Westchester Heavy Construction Laborers Local 60 Health & Welfare Fund, 140 Broadway, Hawthorne, NY 10532
Address:	
Approved	

PART I

STATEMENT OF GROUP ADMINISTATOR

1. Full name of deceased _____ Soc. Sec. _____
2. Date Employment commenced Occupation at time of death _____
3. Date of last active Work _____ If retired, date of retirement _____
4. If date deceased last worked was more than 31 days prior to death, was deceased
   Totally disabled D On leave of absence D on temporary layoff D
5. Name of beneficiary shown on your records _____ Relationship _____

We hereby certify that, to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death for the amount of$ _ _ _ _ _ _

_____ _____

Date Name of Group Administrator

PART II

STATEMENT OF BENEFICIARY OR OTHER CLAIMANT

1. Full name of deceased .....
2. Last legal residence of deceased _____
   STREET CITY OR TOWN STATE ZIP CODE
3. Date of Birth of deceased _____ Date of death _____
4. Cause and circumstances of death .....
5. Are you, the beneficiary, named in the certificate and entitled to the insurance proceeds? _____
6. Your relationship to insured _____ Your date of birth _____
7. Your address _____
   STREET CITY OR TOWN STATE ZIP CODE
8. If you are not the named beneficiary, in what capacity do you make this claim? _____

NOTICE:" ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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." (PURSUANT TO 11 NYC RR86)

I hereby certify that, to the best of my knowledge and belief, the above statements and answers are true.

Date_____ Claimant(s) Signature and Social Security Number

_____ _____

Witness _____

_____