

# Nassau Life Insurance Company

## Claimant's Statement

### Instructions



# NASSAU

CLAIMS DEPARTMENT, P.O. Box 22012 . Albany, New York 12201-2012. [www.nfg.com](http://www.nfg.com)

Proceeds will be paid to the named beneficiary(ies) when the forms listed below are received at the Administrative office, along with any additional requirements.

**1 Certified Copy of the Death Certificate.** Please note, we must keep one certified copy of the death certificate on file.

**2. Claimant's Statement.** This form is to be signed by the person entitled to receive the proceeds of the policy. If there is more than one person, a separate form will need to be furnished for each.

Please refer to the chart below for additional requirements.

#### PROCEEDS PAYABLE TO:

#### STATEMENT SIGNED BY:

#### ADDITIONAL REQUIREMENTS:

|   |   |  |
|---|---|--|
| Estate of the Deceased                    | Executor or Administrator of the Estate of the Deceased | Letters Testamentary or Letters of Administration  |
| Named Beneficiary of legal age            | Named Beneficiary                                       | None   |
| Minor or Mentally Incompetent Beneficiary | Guardian  | Letters of Guardianship  |
| Trust                                     | Trustee   | Evidence that the Trust is in effect and of qualification of Trustee. (Certificate of Authority)                 |
| Contingent Beneficiary                    | Contingent Beneficiary                                  | Evidence of death of all primary beneficiaries   |
| Assignee                                  | Assignee  | If a Collateral Assignment, documentation of the amount claimed by the Assignee, assented to by the beneficiary. |

When the proceeds, or any part of them, are payable to "children" or others of a class, a sworn statement must be furnished, giving the names and the dates of birth of each. If any have died, a death certificate must be provided.

If death occurs outside the United States or Dominion of Canada, the Claimant's Statement and death certificate must be certified by a diplomat or consulate representative of the United State.

#### **For Life Claims**

When an official inquiry as to cause of death has been made, a copy of the verdict or findings, duly certified, must be furnished with this statement.

#### **Spousal Exception for Annuities**

**Please contact the Administrative Office at 1-800-815-8097 to see if you qualify for this exception.** If you qualify, you can continue the contract under your name. This event will be treated as a change of ownership due to death without incurring a taxable event, and a claimant statement will not be necessary unless you decide otherwise. Please refer to the Request for Change of Ownership instructions for all the requirements if applicable.

# Nassau Life Insurance Company Annuity Claimant's Statement



# NASSAU

CLAIMS DEPARTMENT, P.O. Box 22012. Albany, New York 12201-2012. 1-877-815-8097.

### SECTION A.

|  |   |                    |                    |
|--|---|--------------------|--------------------|
| Name Of Deceased   |   | Contract Number(S) | Claim Number(S)    |
| Residence Address  |   | City               | State And Zip Code |
| Date Of Birth  | Source From Which Birthdate Obtained<br><small>(Birth Certificate, Town Records, Etc)</small> | Place Of Birth     |                    |
| Date Of Death  | Cause Of Death  | Place Of Death     |                    |
| In What Capacity, Or By What Title, Do You Claim These Proceeds? |   |                    |                    |

### SECTION B.

**CHOOSE A PAYMENT OPTION:** Please note, the proceeds must be fully paid by the 5<sup>th</sup> anniversary of the date of death.

Lump sum payment.                       Transfer Distribution to a Qualified Account.  
 Periodic distributions to be made on an annual basis on the \_\_\_\_\_ of every \_\_\_\_\_  
(Day) (Month)

### SECTION C.

Under penalty of perjury, I certify that (1) the number below is my correct Taxpayer Identification Number (TIN) and (2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, or (c) the IRS has notified me that I am no longer subject to backup withholding. You must strike out (2) above if you are subject to backup withholding.

I understand that there are penalties for not paying enough tax during the year, either through deficient withholding or estimated tax payments.

**Check for Taxes:**

I am aware that the Federal/State Income Tax Withholding Election form (OL4753) is required to process this request and has been completed and returned with this form

I hereby make claim to Nassau Life Insurance Company and agree that the furnishing of this form by the Company shall not constitute nor be considered an admission by it that there was a contract in force on the life of the person in question nor a waiver of any of its rights or defenses.

**WARNING: 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.**

|   |                                  |                          |                        |                     |
|---|----------------------------------|--------------------------|------------------------|---------------------|
| Claimant's Printed Name                 | Claimant's Street Address        | City                     | State                  | Zip Code            |
| Claimant's Signature                    | Claimant's Social Security/TIN # | Claimant's Date of Birth | Claimant's Telephone # |                     |
| Dated at _____ this _____ day of _____. |                                  |                          |                        |                     |
| <small>City</small>                     | <small>State</small>             | <small>Day</small>       | <small>Month</small>   | <small>Year</small> |

**REFER TO THE INSTRUCTIONS PAGE FOR ASSISTANCE IN COMPLETING THIS FORM**

## Nassau Life Insurance Company

P.O. Box 22012

Albany, NY 12201-2012

### Claim Form Fraud Notices

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**Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, Tennessee, Texas, Washington, West Virginia:** Any person who, knowingly 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, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

**Arizona:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California, Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado:** 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 a 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.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Kentucky:** 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.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

**New York:** WARNING: 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.

**North Carolina:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Pennsylvania:** 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 STATES:** We are required 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.



Nassau Life and Annuity Company (the Company)  
 Nassau Life Insurance Company (the Company)  
 PHL Variable Insurance Company (the Company)  
 Nassau Life and Annuity Insurance Company (the Company)

**Federal/State Income Tax  
 Withholding Election**

**Regular Mail:** PO Box 22012, Albany, NY 12201-2012  
**Overnight Mail:** 15 Tech Valley Drive, Suite 201, East Greenbush, NY 12061-4142

Your election will remain in effect until you submit a new Form OL4753 making a new election. You may submit a new Form OL4753 at any time. If you elect not to have withholding apply to your distributions, or if you do not have enough federal income tax withheld from your distributions, you may be responsible for payment of estimated tax.

**A. Policy/Contract Information**

|                           |                               |
|---------------------------|-------------------------------|
| Policy/Contract Number(s) | Insured(s)/Annuitant(s) Names |
|---------------------------|-------------------------------|

**B. Federal Income Tax**

Complete the following applicable lines.

I **elect to withhold** at a flat rate of 10% or \_\_\_\_\_%.

I **elect to withhold** at a flat amount of \$ \_\_\_\_\_.

I elect **NOT** to have **Federal** income tax withheld.

**C. State Income Tax**

Complete the following applicable lines.

I **elect to withhold** at a flat rate of \_\_\_\_\_%.

I **elect to withhold** at a flat amount of \$ \_\_\_\_\_.

I elect **NOT** to have **State** income tax withheld.

**If you reside in one of the following states you must make a state tax withholding election, otherwise we will withhold for state taxes at the rate of 10%:**

Arkansas    California    Connecticut    District of Columbia    Delaware    Georgia    Iowa    Kansas    Massachusetts  
 Maine    Michigan    North Carolina    Nebraska    Oklahoma    Oregon    Virginia    Vermont

**If you reside in one of the following states, we are required to notify you of your right to withhold for state taxes; however, you are not required to make a state tax withholding election. If you do not make an election, we will not withhold for state taxes.**

Arizona    Indiana    Maryland    Missouri    Montana    New Jersey    New Mexico  
 New York    Utah    Wisconsin    West Virginia

If you reside in a state that is not listed above, you are not required to make a state tax withholding election and you do not need to complete Part C.

**D. Taxpayer/Owner Signature**

**If the Taxpayer is an INDIVIDUAL, complete the following.**

|   |                            |                            |          |
|---|----------------------------|----------------------------|----------|
| Owner Name (Print First, Middle, Last)  | Date of Birth (mm/dd/yyyy) | Social Security No./Tax ID |          |
| Street Address (include Apt. or Suite#) | City                       | State                      | ZIP Code |
| Owner Signature                         | Date (mm/dd/yyyy)          |                            |          |

**If the Taxpayer is a NON-INDIVIDUAL, complete the following.**

|  |                            |                   |          |
|--|----------------------------|-------------------|----------|
| Full Name of Trust, Entity, Corporation or Other   | Social Security No./Tax ID |                   |          |
| Signing in the capacity as:<br><input type="checkbox"/> Trustee <input type="checkbox"/> Partner <input type="checkbox"/> Officer _____ <input type="checkbox"/> Other _____<br>(List corporate title) |                            |                   |          |
| Name (Print First, Middle, Last)   | Signature                  | Date (mm/dd/yyyy) |          |
| Street Address (include Apt. or Suite#)  | City                       | State             | ZIP Code |
| Name (Print First, Middle, Last)   | Signature                  | Date (mm/dd/yyyy) |          |
| Street Address (include Apt. or Suite#)  | City                       | State             | ZIP Code |