

Death Benefits Claim

Please complete both sides, sign, and return this form to the Board of Pensions with a copy of the death certificate and any other required information.

A Information about Deceased Member

Full Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Date of Death _____ Cause of Death _____

Was death the direct or indirect result of an accident? Yes No _____ Date of Accident _____

If yes, please describe (include time and place) _____

*Was the accident related to employment? Yes No _____

Number of Children _____

B Claimant Information (Check appropriate box and provide name, address, and other information below.)

- Spouse (Date of Marriage _____)
- Unmarried dependent child under age 21
- Adult child
- Unmarried dependent child more than 21 years old and permanently disabled (unable to live independently even in a supportive environment)
- Designated beneficiary
- Dependent parent
- Dependent sibling

Full Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Email _____

Date of Birth _____ Phone (_____) _____

Please list names and relationship to the deceased of all other potential claimants in your classification (for example: other siblings)

For additional claimants, attach a separate sheet of paper.

(over)

C Dependent Claimants Only

Did the deceased member claim you as a dependent on his or her most recent tax return? Yes No

If "yes," supply a copy of the first page of the most recent tax return.

What percentage of your living expenses did the member provide during the 12 months immediately preceding and on the date of his or her death? _____ %

If you are a full-time unmarried college student, please provide your expected date of graduation _____ and name of school _____

D Special Information

If the benefits payments should be sent to someone (estate, guardian, trustee, power of attorney, etc.) other than the person listed in the Claimant's Information section, please complete this section and provide documentation.

Name _____

Address _____

City _____ State _____ Zip _____

Estate Tax ID #, if available _____

E Additional Information

F Authorization

I hereby affirm that I

- have carefully read all the above questions and answers;
- have answered each fully, completely, and truly;
- submit this information and attached documents as proof of death; and
- understand that all benefits payments are subject to the terms of the Benefits Plan.

Signature _____ Date _____

Print Name _____

Legal Relationship to Claimant if other than Claimant _____

If you have questions, please call the Board of Pensions at 800-773-7752 (800-PRESPLAN).

*The Board of Pensions of the Presbyterian Church (U.S.A.) reserves the right to request additional information/documentation pertaining to any accidents that contributed to a member's death.

Please send the completed form and all the required information to:

The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN) FAX: 215-587-6215
www.pensions.org