



**Beneficiary's Death Benefit Claim Statement**

In order to process your claim as quickly as possible we need some information about you and about the deceased. Each beneficiary must submit his or her own claim statement. Please return this completed Claim Statement to Building Service 32BJ Health Fund, 101 Avenue of the Americas, New York, NY 10013-1991. Be sure to include a certified copy of the death certificate if it has not yet been provided to the Funds.

**A. Information about you:**

1. Your name (please print or type) \_\_\_\_\_  
First Middle Initial Last
2. Your Social Security No. \_\_\_\_\_
3. Your Date of Birth \_\_\_\_\_ Your sex  Male  Female  
Mo. Day Year
4. Your Phone Number (in case we need to contact you) \_\_\_\_\_ Day ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_  
Area Code Area Code
5. Your Address \_\_\_\_\_  
House Number Street Name Apt./Box No. (if any)  
City State Zip
6. Your Relationship to the deceased. You are the  Husband or Wife  Child  Parent  Other \_\_\_\_\_  
Explain

**B. Information about the deceased:**

1. His/Her Name \_\_\_\_\_  
First Middle Initial Last
2. His/Her Residence Address \_\_\_\_\_  
House Number Street Name Apt./Box No. (if any)  
City State Zip
3. His/Her Marital Status  Single  Married  Widow/Widower  Separated  Divorced
4. His/Her Date of Birth \_\_\_\_\_  
Mo. Date Year
5. His/Her Social Security No. \_\_\_\_/\_\_\_\_/\_\_\_\_
6. We need a certified copy of the death certificate. Is a copy attached?  Yes  No  
 If not, please state why \_\_\_\_\_

The information I have given is, to the best of my knowledge and belief, true and accurate. Under penalties of perjury, I certify that all of the information shown on this form is true and correct to the best of my knowledge.

I know it is a crime in New York State to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to \$5,000 plus the value of the claim.

Please sign below as you would sign on checks.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date