SEAFARERS HEATH AND BENEFITS PLAN

5201 Capital Gateway Drive ▪ Camp Springs, MD 20746 ▪ P: (800) 252-4674 (Option 2) ▪ F: (301) 702-6074 ▪ www.seafarers.org

DEATH BENEFIT APPLICATION

This application is for a Beneficiary of an eligible Participant in the Seafarers Health and Benefits Plan ("Plan") applying for a death benefit within one year of the Participant's death. Complete Section 1 as it applies to the deceased participant and Section 2 as it applies to you. Section 3 of the application must be signed by you in the presence of a Notary Public or witnessed by an authorized SIU/Plan Representative. Complete and return the application by: email: pensions@seafarers.org ; fax: (301) 702-6074; or mail: Pension Department, 5201 Capital Gateway Drive, Camp Springs, MD 20746

1 Participant's Information

- Copy of Death Certificate Required

____
Full Name (First, Middle Initial, Last)

XXX-XX-______ ______________
Social Security Number **Date of Death**

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow(er)

Funeral Expense Deduction

Death benefits are subject to a funeral expense deduction. Please provide a copy of the Itemized Funeral Bill and select one of the following:

- ☐ **No, the funeral bill is unpaid**
- ☐ **Yes, the funeral bill was paid by** ______________________

Death Announcement in the Seafarers LOG

The Participant's death may be announced in a future edition of the Seafarers LOG. If you would also like for him or her to be pictured in the LOG, please include a passport sized photo of the participant along with your application.

2 Beneficiary's Information

You must sign Section 3 in the presence of a Notary Public or witnessed by an authorized SIU/Plan Representative:

- Copy of Social Security Card or ITIN Required
- Copy of supporting document(s) verifying your relationship to the deceased participant

______________________________ ______________
Beneficiary's Full Name (First, Middle Initial, Last) **Relationship**

______________ ______________ ______
Social Security Number **Date of Birth** **Age**

____
Mailing Address

______________ ______ ______
City **State** **Zip Code**

______________ ______________
Cell Phone Number **Home Phone Number**

____
Email

3 Beneficiary's Signature

As the designated beneficiary of the deceased participant above, I understand that in order to qualify for the Plan's maximum benefit that I must be a close relative of the Participant's as considered under the Plan's Rules and Regulations:

Spouse	Grandchild	Grandmother	Mother	Stepmother	Half-sister	Brother	Stepsister	Nephew*
Child	Grandfather	Stepchild	Father	Stepfather	Half-brother	Sister	Stepbrother	Niece*

I acknowledge that the Plan defines a *Niece and Nephew as the children of a participant's brother or sister. I understand that if I am not a close relative of the participant the death benefit will be reduced. I am aware that all death benefits are subject to a funeral expense deduction.

I certify that the information that I have provided on this application is true and correct and I recognize that the Seafarers Health and Benefits Plan will rely on the information for death benefit purposes. I understand if I knowingly provided false or misleading information, I may be guilty of a criminal offense.

______________________________ ______________
Beneficiary's Signature **Date Signed**

THIS SECTION MUST BE COMPLETED BY A NOTARY PUBLIC OR AN AUTHORIZED SIU/PLAN REPRESENTATIVE

State of: ______________________ **County of:** ______________________

On this the ______ day of ______________________, 20______, before me, ______________________________, the undersigned,
Day **Month** **Year** **Notary Public or SIU/Plan Representative's Name**

personally appeared ______________________________ , satisfactorily proven to be the person named in and personally signed, sealed, and
Beneficiary's Name

delivered this Death Benefit Application as his or her act and deed.

______________________________ ______________
Notary Public's or SIU/Plan Representative's Signature **Date Signed**