Winnebago Tribe of Nebraska Tribal Life Insurance | PO Box 687 | Winnebago, Nebraska 68071
PH: 402-878-2272 Ext. 2300 | FX: (833)877-8067 | E: dugan.decora@winnebagotribe.com

Tribal Member Life Insurance Program - Benefit Claim Form

This form is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the Tribal Member Life Insurance Benefit Program of the Winnebago Tribe. This claim is made by the undersigned for the payment of proceeds under the Tribal Member Life Insurance Benefit Program Policy in accordance with Provisions thereof:

1. Full Name of the Deceased _____
2. Is Insured known by other names? _____
3. Address of Insured _____
4. Date of Death _____ Date of Birth _____
5. Cause of Death _____
6. Beneficiary Name _____
7. Beneficiary Full Address _____
8. Beneficiary Phone Number _____
9. Beneficiary's Relationship to Insured_____
10. Beneficiary's Date of Birth_____
11. Beneficiary's Social Security Number_____

*****Please return this form with a certified copy of the Insured's certified death certificate*****

Certification - Under penalty of law, I certify that:

a. I am an eligible to make this claim as a beneficiary of the deceased and am hereby requesting payment under the Winnebago Tribe of Nebraska Tribal Member Insurance Benefit Program.
b. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.
c. The statements I have made on this form are true and correct.

X _____
BENEFICIARY SIGNATURE

DO NOT APPLY SIGNATURE UNTIL IN PRESENCE OF NOTARY PUBLIC

********** FOR NOTARY PUBLIC USE ONLY **********

SWORN TO AND SUBSCRIBED TO BEFORE ME THIS_____DAY OF_____, 20_____

AFFIX SEAL BELOW:

_____
NOTARY PUBLIC SIGNATURE

_____
MY COMMISSION EXPIRES