

DEATH OF OWNER FORM

Mail completed form to:

Upstream Life
PO Box 17039
Winston-Salem, NC 27116



Contact us:

Phone: 866.658.2845
Claims Fax: 336.464.2913

Instructions: This form is to be completed by the beneficiary/claimant and sent along with the policy and a certified certificate of death to the address above.

INFORMATION ABOUT THE DECEASED (Please print all information on this form)

Policy Number(s):

Deceased's Full Name:

List any other names the insured was known by (maiden name etc.)

Date of Death

Date of Birth (mm/dd/yyyy)

Place of Death (if hospital or institution, give name, otherwise exact location):

City, County and State of Death:

I HAVE (CHECK ONE):

☐ Enclosed the **ORIGINAL POLICY** (or Certificate of Coverage), OR

☐ Complete the following **LOST POLICY DECLARATION**

INFORMATION ABOUT THE BENEFICIARY (If the beneficiary is deceased, please attach a copy of the death certificate)

Beneficiary's Full Name

Relationship to Insured

Date of Birth (mm/dd/yyyy)

Mailing Address (check will be mailed to this address):

Phone Number:

Social Security or Tax ID No:

In what capacity are you claiming the proceeds?

☐ Individually (beneficiary) ☐ Other - explain

☐ Trustee ☐ Executor of the Estate

Have you assigned any of the proceeds? ☐ No ☐ Yes - if yes, give amount of assignment, name and address of assignee.

PAYMENT OPTIONS (Choose only one) – Some options may not be available under your Contract. Some Contracts may have Surrender or Market Value Adjustments which may impact TOTAL Death Proceeds payable. Please refer to the actual Contract

☐ **Lump Sum Payment** - This option provides the claim payment in a single sum paid to you. The taxable portion is reported as taxable income in the year the check is issued. If it is after December 31 of the year following the death, this is the only payment option available.

☐ **Income Payment** - This option provides series of fixed income payments, distributed over your lifetime or a fixed number of years, based on your elections below. Payments must begin no later than December 31 of the year following the date of death. Once payments begin, they cannot be changed.

Income Option: ☐ Period Certain ☐ Single Life ☐ Single Life & Period Certain ☐ Joint & Survivor

Duration: ☐ 5 years ☐ 10 years ☐ 15 Years ☐ 20 Years

Only applies to Period Certain options. If applicable and no duration is elected, We will default to 5 years.

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

If no frequency is elected, we will default to Annually.

☐ **Deferral** - This option delays your claim payment for up to 5 years from the date of death. The claim must be paid on or before December 31 of the 5th year following the date of death. You may request your claim payment at any time within the deferral period by submitting a new claim form.

☐ **Qualified Policies** - This option is not available if the decedent has reached RMD age. You must continue to take Required Minimum Distributions beginning in the year after the decedent's death.

☐ **Spousal Continuation** - This option continues the existing policy in your name with the original issue date and same policy number. No death benefit distribution will occur, and this ownership change is not taxable. This option is only available if your spouse is the deceased and you are the sole beneficiary or joint owner. This option is not available on an Inherited IRA. This option must be process by December 31 of the year following the date of death.

DISTRIBUTION OF FUNDS

Designated Beneficiary Name/Name of Estate

Date of Birth (mm/dd/yyyy)

Social Security or Tax ID No (TIN)

Phone Number

Street Address (City, State, Zip)

Mailing Address (City, State, Zip)

Email Address

Relationship to Deceased

TAX WITHHOLDING

The IRS requires that we withhold 10% Federal Income Tax from your payment unless you advise us otherwise.

If you **do not** want us to withhold 10% of your payment, please select one of the options below. Do

- ☐ not withhold Federal or State income taxes from my payment
- ☐ Withhold _____% Federal income tax from my payment.
- ☐ Withhold _____% State income tax from my payment.

Please consult a tax advisor for more information on withholding requirements for your state.

Note: Whether or not taxes are withheld, you will be liable for payment of all applicable federal and state income taxes on the taxable portion of this distribution. You may also be subject to penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

CERTIFICATION OF TAXPAYER IDENTIFICATION

Under penalties of perjury, I certify:

1. The Social Security Number or Taxpayer Identification Number shown on this form is correct;
2. I am not subject to backup withholding due to failure to report interest or dividend income;
3. I am a U.S. citizen or other U.S. person (as defined in the Internal Revenue Code); and
4. I am not subject to FATCA reporting because I am a U.S. Person and the account is located with the United States.

Certification Instructions - You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest or dividends on your tax return. If you are not a U.S. citizen or other U.S. person for tax purposes, please cross out certifications 3 and 4 and complete and return to us the appropriate IRS documentation.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholdings.

Owner(s) and/or Assignee(s) Signature(s) (required)

Title (if corp. or trust)

Date (mm/dd/yyyy)

Joint Owner(s)

Title

Date (mm/dd/yyyy)

Other Required Signature (if any)

Name and Title

Date (mm/dd/yyyy)

Acknowledgement and Release for Information

I **hereby certify** that the above information is both complete and true to the best of my knowledge and belief. I acknowledge that I have read the authorization for information below and fraud notice attached. If my funds will be deposited directly to a bank account. I acknowledge the receipt and satisfaction of the full amount owed for all claims on the referenced policy(s). The furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I **authorize** all physicians, hospitals, clinics or any other person, to disclose any information acquired thereby and furnish all such information to Upstream Life And Annuity Insurance Company for the purpose of adjudicating this claim. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

Signed at (City, County, State): _____ on ____ / ____ / ____

Claimant Signature: _____

Witness's Signature: _____ (An unrelated adult person)

Witness's Printed Name: _____

Fraud Notices

"I understand that some states require Upstream Life to notify me that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. "[Residents of AK, AZ, CA, CO, FL, KY, ME, MN, NE, NH, NJ, NM, NY, OH, OR, PA, PR, TN, and WA, refer to the specific notices listed below.]

Alaska, Arizona, Nebraska, New Hampshire and Oregon Residents: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison."

California Residents: "For your protection California law requires the following notice to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Colorado Residents: "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 provide 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. "

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

Kentucky, Ohio and Pennsylvania Residents: "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."

Maine, Tennessee and Washington Residents: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

Minnesota Residents: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

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

New Mexico Residents: "Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor no more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years, if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

SPECIAL NOTICE TO ILLINOIS RESIDENTS:

Upon completion of the routine claim review and receipt of required documents, we will promptly review and evaluate the claim. A valid claim that is not paid within 31 days from the date we receive due proof of loss will include interest due and payable from the date of death at a rate of 10.0%.