Fax: (212) 298 – 9885
Email: disabilitydeath@dc37.net

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN
APPLICATION FOR DEATH BENEFITS

Name of Deceased: _____ **SSN/PID #:** _____
First Name **Last Name**

Last Legal Residence: _____
(#) **(Street)** **(City)** **(State)** **(Zip Code)**

Date of Death: _____

RETIREE: ☐ **Yes** ☐ **No** If no, please give employment information.

LAST EMPLOYMENT:

Job Title: _____ **Last Day Worked:** _____

Exact Work Location: _____

Work Location Telephone #: _____

PLEASE COMPLETE A OR B:

A. FULL NAME OF BENEFICARY:

Address: _____
(No. and Street) **(City)** **(State)** **(Zip Code)**

Your SSN: _____ **Telephone #:** _____ **E-mail Address:** _____

Are you age 18 or over? _____ **Relationship to deceased member** _____

B. IF YOU ARE NOT A BENEFICIARY, IN WHAT CAPACITY DO YOU MAKE THIS CLAIM?

_____

Full Name of Claimant: _____ **Telephone#:** _____

Address _____
(No. and Street) **(City)** **(State)** **(Zip Code)**

Your SSN / Tax ID#: _____ **E-mail Address** _____

MUST BE COMPLETED IN FULL TO PROCESS CLAIM

_____
(Your signature in full)

STATE OF _____ **COUNTY OF** _____ **on** _____ **20** _____ **before me personally**

came _____ **to be known, and known to me to be the individual(s)**
(Print name)

described in, and who executed the foregoing RELEASE, and duly acknowledge to me that he executed the same.

Notary Stamp Here:

_____
Notary Public Signature