



## FUNERAL ASSIGNMENT OF LIFE INSURANCE CLAIM PROCEEDS

-Please Print or Type in Dark Ink-

I, OR WE, THE UNDERSIGNED BENEFICIAR(IES), HEREBY STATE THAT I AM, OR WE ARE, THE BENEFICIAR(IES) OF THE GROUP POLICY (DEFINED BELOW) ISSUED BY RENAISSANCE (DEFINED BELOW), AND ENTITLED TO RECEIVE THE DEATH BENEFIT PAYABLE ("PROCEEDS") UNDER THE SAID GROUP POLICY. I, OR WE HEREBY ASSIGN AND TRANSFER TO THE ASSIGNEE (DEFINED BELOW) CERTAIN AMOUNT OF THE PROCEEDS FOR CERTAIN FUNERAL OR BURIAL EXPENSES AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS:

RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF AMERICA AND RENAISSANCE LIFE & HEALTH INSURANCE COMPANY OF NEW YORK ("RENAISSANCE") MAY, IN ITS SOLE DISCRETION, ACCEPT THIS ASSIGNMENT OF LIFE INSURANCE PROCEEDS (HEREAFTER "ASSIGNMENT"), PROVIDED ALL CONDITIONS OF THE ASSIGNMENT ARE MET AND THIS FORM IS PROPERLY COMPLETED, SIGNED AND NOTARIZED. THE FURNISHING OF THIS FORM, OR OF ANY FORMS SUPPLEMENTAL THERETO, BY RENAISSANCE SHALL NOT CONSTITUTE NOR BE CONSIDERED AN ADMISSION BY RENAISSANCE OF LIABILITY, NOR A WAIVER OF ANY OF RENAISSANCE'S RIGHTS OR DEFENSES OR ACCEPTANCE OF THE ASSIGNMENT.

### SECTION I | INSURED INFORMATION

Full Legal Name of the Insured (*Last, First, MI*):

Street Address of Insured ( <i>Include Apt#/Suite</i> ):	City:	State:	ZIP Code:
Policyholder/Employer:	Group Policy Number:		

### SECTION II | ASSIGNEE INFORMATION

Name of Assignee/Funeral Services Provider:	Phone:		
Address ( <i>Include Apt#/Suite</i> ):	City:	State:	ZIP Code:

### SECTION III | ASSIGNMENT DETAILS

In consideration of merchandise furnished, services rendered and other expenses requested by me or us and incurred in connection with the funeral, preparation, burial and final expenses of the Insured, I or we hereby assign and transfer to Assignee the total sum of \*\$\_\_\_\_\_ ("Funeral Payment"). Such Funeral Payment shall be made directly to the Assignee to the address stated in this Assignment, and shall be apportioned equally among the beneficiaries signing this form unless otherwise stipulated in the table below:

Beneficiary A: Amount: \$ _____	Beneficiary B: Amount: \$ _____
Beneficiary C: Amount: \$ _____	Beneficiary D: Amount: \$ _____
Total Sum: *\$ _____	

## SECTION IV | CONDITIONS OF THIS ASSIGNMENT

1. This Assignment is subject to all the terms and conditions of the Group Policy.
2. The amount of the policy proceeds must be sufficient to cover the amount assigned.
3. If the total sum above exceeds the itemized funeral bill of the Assignee, Renaissance will not accept this Assignment.
4. Renaissance will not accept an Assignment from a Trust, Estate or a minor.
5. If multiple beneficiaries are assigning their portions of proceeds, all such beneficiaries must complete and sign the Assignment of Life Insurance Proceeds form.
6. A copy of the itemized funeral bill must be submitted prior to payment of assigned benefits.
7. Funeral Payment to the Assignee will be the same as if the payment were made directly to the beneficiaries.
8. The undersigned beneficiar(ies) agree to and hereby do indemnify and hold harmless Renaissance, its officers, directors, employees, policyholders and agents, for all costs, including reasonable attorney's fees, for defense or payment of any claims brought by or on behalf of any third party regarding the payment of proceeds under the Policy, or any further actions Renaissance may take in connection with the Policy in accordance with this Assignment.
9. Renaissance does not assume any responsibility for the validity or the sufficiency of this Assignment.
10. This Assignment, when received and accepted by Renaissance at the designated addresses below, shall become effective as of the date of its execution, and shall be subject to any payment made or action taken by Renaissance prior to such filing.
11. The undersigned declares that no proceeding in bankruptcy is pending against him/her and that his/her property is not subject to any Assignment for the benefit of creditors.
12. This Assignment shall be binding upon all beneficiaries signed below, their executors, administrators, or assigns forever and is irrevocable.

## SECTION V | BENEFICIARY SIGNATURE(S)

**BENEFICIARY A.)** Print Name (Last, First, MI):

Phone:

Address (Include Apt#/Suite):

City:

State:

ZIP Code:

Email Address:

Signature of Beneficiary: *X*

Date Signed:

**BENEFICIARY B.)** Print Name (Last, First, MI):

Phone:

Address (Include Apt#/Suite):

City:

State:

ZIP Code:

Email Address:

Signature of Beneficiary: *X*

Date Signed:

**BENEFICIARY C.)** Print Name (Last, First, MI):

Phone:

Address (Include Apt#/Suite):

City:

State:

ZIP Code:

Email Address:

Signature of Beneficiary: *X*

Date Signed:

**SECTION V | BENEFICIARY SIGNATURE(S) (CONTINUED)**

**BENEFICIARY D.)** Print Name (Last, First, MI):

Phone:

Address (Include Apt#/Suite):

City:

State:

ZIP Code:

Email Address:

Signature of Beneficiary: X

Date Signed:

**SECTION VI | NOTARY INFORMATION**

City and State of: \_\_\_\_\_ County of: \_\_\_\_\_,  
this \_\_\_\_\_ day of \_\_\_\_\_,  
(Day) (Month) (Year)

I, \_\_\_\_\_,  
a Notary Public in and for said State, do hereby certify that \_\_\_\_\_

\_\_\_\_\_ personally appeared the above noted individual(s), personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that \_\_\_\_\_

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**PLEASE RETURN COMPLETED FORM BY:**

**SECURE FAX:** 607-773-2276

**SECURE EMAIL:** GroupClaims@RenaissanceFamily.com

**MAIL:** Renaissance Life & Health Insurance Company, PO Box 1596 Indianapolis, IN 46206

—State Fraud Warnings on Following Pages—

Underwritten by Renaissance Life & Health Insurance Company of America, Indianapolis, IN, and in New York by Renaissance Life & Health Insurance Company of New York. Both companies may be reached at PO Box 1596, Indianapolis, IN 46206. Products may not be available in all states or jurisdictions.

## LIFE AND DISABILITY STATE FRAUD WARNING STATEMENTS:

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW. PLEASE SEE BELOW FOR STATE-SPECIFIC VARIATIONS OF THIS FRAUD NOTICE.**

**CALIFORNIA: WARNING:** FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

**FLORIDA:** 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.

**NEW YORK (EXCLUDING LIFE INSURANCE):** 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.



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