



Request for Payment of Benefits

Form No. 15700 CO, FL, KS, MD, ND, NV, NY (11/2008)

This form contains instructions to file a claim for insurance benefits and is supplied by the Company upon request without prior verification of coverage and without any assurances made by the Company to the recipient that he, she, or it will be the appropriate payee or beneficiary of such benefits.

PAYMENT OPTIONS

You are eligible to select one or a combination of the following payment options, unless the policy restricts your rights.

1. Immediate Payment Options

A) Interest-Bearing Checking Account

- Proceeds are immediately made available to you by means of an interest-bearing checking account. The account will be opened in your name, and you will receive a supply of checks with which you can immediately access all or a portion of the funds by writing checks for \$250 or more. The funds in the account earn interest at a competitive, variable rate beginning on the date that proceeds are paid. The interest rate will always equal or exceed the national average for bank money market deposit accounts, as measured by the Bank Rate Monitor National Index. (The checkbook method is not available if the proceeds are less than \$5,000.00 or if more than one person would be required to sign a check).

B) Lump Sum Check

2. Interest Option

- An interest-bearing contract. There are no penalties or charges for withdrawals.

3. Installment Payments

- Pays your insurance proceeds plus interest in annual or more frequent installments for a period you select or in an amount you select.

4. Life Income Options

- Life Income Options pay you a guaranteed income for life.

Additional descriptions of above options 2, 3 & 4 and eligibility requirements are provided with our election forms.

To obtain election forms or more information about our interest-bearing checking account or payment options 2, 3 and 4, including our current rates and estimates of income you can receive, call our Toll Free Number.

1-800-326-6744

INSTRUCTIONS

If you need help in completing this form or have a question, contact your MONY Representative or the MONY office that provided this form.

MARITAL STATUS OF INSURED & CLAIMING BENEFICIARY

If you are submitting a claim as the SPOUSE of the insured, then you represent to MONY that (i) you were lawfully married to the insured at his/her death; and (ii) no divorce or annulment had been granted or issued to dissolve your marriage; and (iii) no marital agreement (e.g. prenuptial, postnuptial, separation, property settlement or marital property agreement) precludes, prohibits, or impairs your right to make this claim.

If you are submitting this claim as the FORMER SPOUSE of the insured, then you represent to MONY that your divorce decree or decree of annulment does not disqualify you as a beneficiary and you have no reason to believe that you are otherwise disqualified.

FOR PROMPT PROCESSING, PLEASE COMPLETE THIS FORM AND SUBMIT WITH A CERTIFIED COPY OF THE DEATH CERTIFICATE, THE ORIGINAL POLICY(IES) AND ANY OTHER REQUIREMENT FROM THE LIST BELOW THAT MAY BE APPLICABLE.

- Request for Payment Form (Page 4)**
- Item #1-10** are about the **deceased insured**. Your answers will speed payment, avoid follow-up questions and help us determine all benefits to which you are entitled. In 1, please list all names by which the insured may have been known.
- Item #11** identified the **person making the claim**.
- Item #12** is to be completed by the **Trustee** if the payment is to be made to a trust. A Trustee not identified by name in the policy should submit evidence of authority.
- Item #13** identifies all beneficiaries both living and dead, and his, her or its living beneficiaries' share of proceeds.
- Item #14** asks **how you want to be paid**.
Your payment options are listed on the front of this form. For current rates and estimates of the income you can receive, call toll-free 1-800-326-6744.
Box A Check this box if you want all the proceeds (or any applicable balance remaining if you check Box C) paid to you under the Interest-Bearing Checking Account described on page one of this form.
Box B Check this box if you want all the proceeds (or any balance remaining if you check Box C) paid to you in a Lump Sum Check.
Box C Check this box if you want all or **part** of the proceeds settled under an Interest, Installment, or Life Income Option, with the balance paid to you under one of the Immediate Payment Options (Box A or B) that you choose.
- Item #15** Each beneficiary must complete and sign the Required Beneficiary Information Section. If there are more than three beneficiaries, each additional beneficiary must complete the Beneficiary Choice of Settlement form #15822. This form can be obtained from the MONY office that is handling the claim.
- Item #16** **Authorization for release of information. Signature of person completing form is also required in this section.**
- Death Certificate**
Provide an **original or certified copy** of certificate of death. Photocopies are not acceptable and are sometimes prohibited by law.
- Policy(ies)**
Provide the original policy(ies). If the original policy(ies) is/are lost, request a Certification of Loss form from the MONY office that sent this form. If the original policy(ies) is/are unavailable to you, but has not been lost or destroyed, then you should explain the circumstances in a written statement attached to the completed form.
- Interest or Income Option Election Form**
To request an Interest, Installment Payments or Life Income Options election form, please call the toll free number shown on Page 1.
- Certificate of Court Appointment**
If the proceeds are payable to an **Executor, Administrator, Guardian, Trustee under will, or other legal representative**, provide a certified copy of the appointment (or evidence of authority) by the Court.
- Newspaper Clippings** concerning the death, if available.
- Attending Physician's Statement:** Only required if a policy was issued or reinstated within TWO years prior to death, OR if death was by suicide, homicide or accident.
- Beneficiary Choice of Settlement # 15822**...if there are four or more beneficiaries.
- Statement as to Children #3557**...If children were not identified by name in the actual beneficiary designation on record with the Company, request form #3557 from the MONY office that provided this form.
- Power of Attorney Instrument**
If you are claiming as Attorney in Fact on behalf of the beneficiary, send in the Power of Attorney instrument.
- Other:**

Colorado Fraud Warning

“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 a n insurance company who knowingly provides 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 Fraud Warning

“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.

Maryland Fraud Warning

“Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

New York Fraud Warning

“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.

NY STATE RESIDENTS READ AND SIGN ONLY: I have read and understood the New York State fraud warning.

Beneficiary’s Signature _____ Date _____

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Beneficiary’s Signature _____ Date _____



MONY Life Insurance Company
P.O. Box 4830
Syracuse, NY 13221

MONY Life Insurance Company of America
P.O. Box 4720
Syracuse, NY 13221
"Not licensed in NY"

Please read Instructions on Page 2

DATE RECEIVED IN AGENCY

Policies under which payment is required:

1. Insured's First Name, Middle Initial, Last Name					
2. Birthdate of Insured		3. Place of Birth		4. Date of Death	
5. Place of Death (City and State)					
6. Insured's Address Street		City	State	Zip Code County	
7. Principal Cause of Death		8. Occupation of Insured at Death-date last worked		9. When did the health of Insured first begin to be affected?	
10. Please list all other insurance on the life of the Insured. If additional space is needed, please attach a separate sheet. Company		Amount	11. Are you the beneficiary name in the policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, in what capacity do you request payment? Spouses and former spouses should refer to instructions.		
		12. If proceeds are payable to a living trust...Name and date of trust Name Date			
13. Information on all beneficiaries both living and dead. Identify beneficiaries who predeceased the Insured by writing "Deceased" after name.					
Name If a name differs from that on our records, state old and new name		Social Security No. or Taxpayer ID No.		Date of Birth if living, if not, Date of Death	Share of Proceeds (%)
_____		_____		_____	_____
_____		_____		_____	_____
_____		_____		_____	_____
_____		_____		_____	_____
14. Payment Options: (See cover page of this form for explanation of your Payment Options.)					
<input type="checkbox"/> A. Pay all proceeds (or any applicable balance remaining if Box C is checked) immediately. If proceeds equal \$5,000. or more and meet the other eligibility requirements, they will be placed in an interest bearing checking account.					
<input type="checkbox"/> B. Pay all proceeds (or any balance remaining if Box C is checked) in a Lump Sum check.					
<input type="checkbox"/> C. Pay any part or all of the proceeds into a Interest, Installment or Life Option, with any balance being paid under the other payment option chosen above (Box A or B).					
15. Signatures: Each beneficiary must complete and sign required Beneficiary Information Section. Additional space on page 4 for two additional beneficiaries. If more than three beneficiaries, each additional beneficiary must complete Beneficiary's Choice of Settlement form #15822. If you are an ex-spouse/spouse then your signature will bind you to the representations set forth in the instructions.					
REQUIRED BENEFICIARY INFORMATION. THIS SECTION MUST ALWAYS BE COMPLETED IN FULL (Please print)					
Beneficiary's Name _____		Date of Birth _____		Social Security or Taxpayer ID # _____	
Mailing Address _____		Telephone # _____			
(Street)		(City)	(State)	(Zip Code)	(Daytime)
(If mailing address is a P.O. Box, please supply a street address)					
If the taxpayer ID or Social Security number is not supplied, the policy(ies) may be subject to federal and state withholding. Under the penalties of perjury, I certify that the information supplied on this form is true, and complete, and that I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.					
X _____			_____		
Beneficiary's Signature-SIGN AS YOU WOULD ON CHECKS			Date		

REQUIRED BENEFICIARY INFORMATION. THIS SECTION MUST ALWAYS BE COMPLETED IN FULL (Please print)

Beneficiary's Name _____ Date of Birth _____ Social Security or Taxpayer ID # _____

Mailing Address _____ Telephone # _____
(Street) (City) (State) (Zip Code) (Daytime)

(If mailing address is a P.O. Box, please supply a street address)

If the taxpayer ID or Social Security number is not supplied, the policy(ies) may be subject to federal and state withholding. Under the penalties of perjury, I certify that the information supplied on this form is true, and complete, and that I am not subject to backup withholding either because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

X _____
Beneficiary's Signature-**SIGN AS YOU WOULD ON CHECKS** Date

REQUIRED BENEFICIARY INFORMATION. THIS SECTION MUST ALWAYS BE COMPLETED IN FULL (Please print)

Beneficiary's Name _____ Date of Birth _____ Social Security or Taxpayer ID # _____

Mailing Address _____ Telephone # _____
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X _____
Beneficiary's Signature-**SIGN AS YOU WOULD ON CHECKS** Date

16. Authorization: I have read any attending physician's statement furnished by me herewith and ask that it be made a part of this request.

AUTHORIZATION FOR RELEASE OF INFORMATION RE: _____
(Insured's Name)

TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, MEDICAL INFORMATION BUREAU, EMPLOYERS, AND OTHER PERSONS OR INSTITUTIONS: This authorizes you to give The MONY Life Insurance Company ("MONY"), or its insurance affiliate, MONY Life Insurance Company of America, or its authorized representative who is employed to assist in the evaluation of the claim on the above individual, any information, data or records you may have regarding this individual, his/her employment or condition (including records pertaining to psychiatric, drug or alcohol use history; and disability he/she may have had; and the prognosis and treatment of HIV infection, serious communicable diseases and sexually transmitted diseases as well as positive HIV antibody test results). I understand that any information obtained pursuant to this authorization will be used to evaluate this claim and may be transferred to any agency or person employed by MONY to assist with this purpose. This authorization is valid during the pendency of this claim, unless I revoke it by writing to MONY. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy or facsimile transmission copy of this authorization may be accepted by you.

X _____
Signature of Person Completing the Request for Payment Information Daytime Telephone Number Date