Section4: Decedent/Claimant Information (This section should be completed by the claimant.)

If beneficiary is a minor, boxes 55-56 should be completed. The legal guardian's information should be entered in boxes 46 and 50-53.

39. Name of Deceased	40. Plan Number	41. Deceased's Social Security Number
Stephen Kostinden	00530438	010-52-8486

42. Deceased's Date of Birth	43. Date of Death	44. Cause of Death
8/28/58	10/28/19	

45. Name of Person Claiming Benefit	46. Social Security Number	47. Date of Birth
Maureen A. White	014.42.9595	OCTOBER 4, 1951

48. Relationship to Deceased	49. If Deceased is your spouse, date of marriage	50. Telephone Number
Sister	___/___/___	Home: Cell: 617.851.0701

51. Address	City	State	Zip
8 Carnation Cir Unit D	Reading	MA	01867

52. Email Address	53. Please Indicate Acceptable Methods of Contact
mwhite1004@verizon.net	☑ Cell ☐ Home ☑ Email

54. Have you assigned any portion of this benefit to a funeral home, mortuary, crematorium, etc. to cover final expenses? **If so, please attach the notarized assignment(s) for final expenses.** ☐ Yes ☑ No

Numbers 55-56 only need to be completed if the beneficiary is a minor.

55. Name of Guardian of Minor Beneficiary	56. Has guardianship of the minor's estate been established? **If yes, please attach court order.** ☐ Yes ☐ No

Method of Payment

You may select from two options: 1) Lump sum payment via a single check or 2) Guardian Asset Account. Note: If you do not elect an option, the proceeds will be paid in a single lump sum. **If you prefer payment via a lump sum check, please check below:**

☑ Lump sum payment via a single check

2) Guardian Asset Account. This option is only available if the proceeds exceed $10,000.00. This is an interest bearing draft account administered by the Bank of New York Mellon.. Additional information is required in order to elect this option. If you are interested in the Guardian Asset Account payment option, prior to submitting your claim form, please contact us at 1-800-525-4542 to request the Guardian Asset Account election package, which includes disclosure information mandated by state law for your review prior to electing this payment option.

By signing below, I acknowledge:
1. All information I have given is true and complete to the best of my knowledge and belief.
2. I have read the applicable Fraud Warning(s) provided in this form.

Under penalty of perjury, I certify:
1. That the number shown on this form is my correct taxpayer identification number; and
2. That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and
3. I am a U.S. citizen, or a U.S. resident for tax purposes.

(Please note: You must cross out item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest and dividend income on your tax return.)

I make claim to The Guardian Life Insurance Company of America. I agree that the written statements and affidavits of all the physicians who attended or treated the deceased and all other papers called for by Guardian are part of this Group Life Claim Form I agree that furnishing this form or any supplement to Guardian is not an admission by it that there was any insurance in force on the life of the person in question nor a waiver of any of its rights or defenses. I waive all provisions of law expressly forbidding any consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information about the deceased in its possession to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care, pharmacies or pharmacy benefit managers regarding the deceased's medical history, mental or physical condition, or treatment. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan.

Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I have the right to cancel this authorization in writing at any time. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulation governing privacy. I know that I may request and receive a copy of this authorization. I agree that a photocopy of the authorization shall be as valid as the original. I agree that this authorization is valid up to 24 months (12 months in Kansas).

"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. In New York the person 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."

BEFORE SIGNING THIS CLAIM FORM, PLEASE READ THE WARNING FOR THE STATE WHERE YOU RESIDE AND FOR THE STATE WHERE THE INSURANCE POLICY UNDER WHICH YOU ARE CLAIMING A BENEFIT WAS ISSUED.

The IRS does not require consent to any provision of this document other than the certification to avoid backup withholding."Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim."

Signature: Maureen A. White Date: 12/9/19

REGISTRY DIVISION OF THE CITY OF BOSTON

COUNTY OF SUFFOLK, COMMONWEALTH OF MASSACHUSETTS, UNITED STATES OF AMERICA

Certificate Number

№ 871580

I, the undersigned, hereby certify that I hold the office of _____ City Registrar of the City of Boston and I certify the following facts appear on the records of Births, Marriages and Deaths kept in said City as required by law.

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07012019

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

CERTIFICATE OF DEATH

State File #	**2019 048294**
Registered #	**6369**

DECEDENT

Place of Death **MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MA**

Date of Death **OCTOBER 28, 2019** *Age* **61 YRS** *Sex* **MALE**

Current Name **KOSTINDEN , STEPHEN ---**

Surname at Birth or Adoption **KOSTINDEN** *SSN* **010-52-8486**

AKA **---**

Date of Birth **AUGUST 28, 1958** *Birthplace* **BOSTON, MASSACHUSETTS**

Residence **149 FENLEY STREET, REVERE, MASSACHUSETTS 02151**

Race **WHITE**

Education **HIGH SCHOOL GRADUATE OR GED**

Marital Status **DIVORCED**

Occupation/Industry **BUYER/PRODUCE INDUSTRY**

Last Spouse – Last, First, Middle (Surname at Birth or Adoption) **KATZ, JEAN (KATZ)**

Decedent: U.S. Veteran (Most Recent) **NO**

Parent Name – Last, First Middle (Surname at Birth or Adoption) **KOSTINDEN, MARGARET (PAPPAS)**

Birthplace **MASSACHUSETTS**

Parent Name – Last, First Middle (Surname at Birth or Adoption) **KOSTINDEN, WILLIAM (KOSTINDEN)**

Birthplace **MASSACHUSETTS**

MEDICAL CERTIFIER

Part I. Cause of Death – Sequentially list immediate cause then antecedent causes then underlying cause

Interval between onset and death

a. Immediate Cause (Final condition resulting in death)
HYPOVOLEMIC SHOCK **--- HRS.**

b. Due to or as a consequence of:
HEMORRHAGE **--- HRS.**

c. Due to or as a consequence of:
RUPTURED ABDOMINAL AORTIC ANEURYSM **--- HRS.**

d. Due to or as a consequence of:
--- **---**

Part II. Other significant conditions contributing to death but not resulting in underlying cause
---

Manner of Death: **NATURAL**

Time of Death: **12:54 AM**

Result of Injury: **NO**

Certifier **PAUL F. CURRIER, MD** *Lic #* **211099**

Addr. **55 FRUIT STREET, BOSTON, MASSACHUSETTS 02114**

DISPOSITION

Funeral Licensee/ Designee **FREDERICK N DELLO RUSSO** *Lic #* **5168**

Facility/Addr. **DELLO RUSSO FUNERAL HOME, MEDFORD, MASSACHUSETTS**

Immediate Disposition **CREMATION**

Date of Immediate Disposition **NOVEMBER 05, 2019**

Place/Address **WOODLAWN CEMETERY, 302 ELM STREET, EVERETT, MASSACHUSETTS 02149**

Date of Record **OCTOBER 30, 2019**

Date of Amendment **---**

Patricia A McMahon

REGISTRAR, CITY OF BOSTON

DATE ISSUED: ***DECEMBER 06, 2019***

WITNESS my hand and the SEAL of the CITY REGISTRAR

on this _____ Day of DEC 06 2019 A.D._____

Patricia A McMahon *City Registrar*

By Chapter 314 of the Acts of 1892, "the certificates or attestations of the Assistant City Registrars shall have the same force and effect as that of City Registrar."

I further hereby certify that by annexation, the records of the following cities and towns are in the custody of the City Registrar of Boston:

	Annexed
East Boston	1637
South Boston	1804
Roxbury	1868
Dorchester	1870
Charlestown	1874
Brighton	1874
West Roxbury	1874
Hyde Park	1912

BOSTON 6369

REVERE 415

STATE VOL/PG: /

If U.S. war veteran, specify war/conflict(s) ---			
Branch of military (most recent) ---		*Rank/organization/outfit(most recent)* ---	
Date entered (most recent) ---	*Date Discharged (most recent)* ---	*Service Number(most recent)* ---	
Place of Death Type **HOSPITAL - INPATIENT**		*Date of Pronouncement* ---	*Time of Pronouncement* ---
RN/NP/PA Pronouncement? **NO**	*Name of RN/NP/PA Pronouncing Death* ---		*Lic #* ---
RN/NP/PA Employing Agency or Institution ---		*Name of Physician or Medical Examiner notified* ---	
Was M.E. Notified? **YES**	*Provider in charge of patient's care, if not certifier* **MATTHEW EAGLETON, MD**		
Autopsy Performed? **NO**	*Findings available for Cause?* ---	*Tobacco contribute to death?* **NO**	*Pregnancy Status, if female* ---
Date of Injury ---	*Time of Injury* ---	*Injury at Work?* ---	*If Transportation Injury, specify:* ---
Place of Injury ---		*Location/Address of Injury:* ---	
Describe How Injury Occurred ---			
Expanded Race: **WHITE** *Ethnicity:* **AMERICAN**			
Informant Name **DEBORAH --- GREENLEAF** *Addr.* **119 EMERALD STREET, MEDFORD, MASSACHUSETTS 02155**			*Relationship* **SISTER**
Date Disposition Permit Issued: **OCTOBER 30, 2019** *State Tracking No.* **048294**		*Board of Health Agent* **JAMES V. IMPRESCIA** *Local Permit No.* **B19048294**	