

AFFIDAVIT OF INFORMATION CONCERNING DECEASED MEMBER

Failure to supply all information may delay or otherwise affect capital credits retirement/payout on this account.

STATE OF _____) COUNTY OF _____)

_____, the undersigned, of lawful age and being first duly sworn,
on oath states:

That undersigned is familiar with the following facts concerning _____,
a deceased member of the S & T Telephone Cooperative Assoc. SS# _____

- 1. Date of Death: _____ (a copy of the death certificate is required)
- 2. Place of Death: _____
- 3. Is Spouse: Surviving _____ Deceased _____

If surviving, please provide name, address and SS # of spouse:

SS# _____

- 4. Names and Addresses of ALL Children (indicate any that are deceased):

- 5. Names and Addresses of ALL Surviving Children of deceased children (note deceased parent):

6. Did Deceased leave a will? _____
7. Has Will been admitted to Probate? _____
8. Name and Address of Executor or Administrator of Estate, if any: _____

9. Name and Address of Probate Court in which Estate is administered, if any: _____

10. Has Estate been closed?: _____
11. If Estate has been closed, please send copy of Journal Entry of Final Settlement of the Estate. If the Estate has not been closed, please send Probate Court Certificate or certified copy of letters of administration showing name and address of duly appointed, qualified and acting Executor or Administrator.
12. Name and Address of Attorney representing Executor or Administrator, if any:

13. Have all funeral expenses, debts and inheritance and estate taxes been paid? _____
14. Approximate total value of Estate of Decedent (including life insurance owned by Decedent)
 \$ _____ (this is for the purpose of knowing if inheritance or estate tax waiver or release is required).
15. At any time, was the decedent residing at a nursing home or assisted living facility? Yes ___ No ___
 Was the facility receiving Medicaid or state funds for the care of the individual? Yes ___ No ___
 If yes, please provide the name and address of the facility.

- (The State of Kansas has the right to request reimbursement of Medicaid expenses.)

16. Method of payment: The Board passed a policy that allows estates to be paid out based on the following methods? (Please check one payment method)

_____ (a) Receive prompt settlement (Lump Sum) of the decedent's capital credits discounted at the present value of the capital account.

_____ (b) Receive non-discounted payment of the capital credits pursuant to the general retirement of the capital credit, currently paid out over a 25 year period.

The undersigned states that the foregoing information is true and correct to the best of the knowledge and belief of undersigned.

Signature

State of _____

County of _____

Signed or attested before me on this _____ day of _____, 20____.

(Signature of notarial officer)

(Seal)

Title

My appointment expires: _____

**All Heirs Must Sign This Form In Order For A
Check To Be Issued To Individual(s)**

WRITTEN DIRECTION TO S & T TELEPHONE COOPERATIVE
REGARDING CAPITAL CREDITS

We, the undersigned, being all of the lawful heirs of _____,
a deceased member of the S&T Telephone Cooperative Association, hereby direct said association to issue a
check for all capital credits and membership refunds due said deceased member to the following person(s),
Estate or Trust:

Each person to whom the capital credits are directed to be paid, must provide a completed Indemnification
Agreement. If payable to an Estate or Trust, please include the Tax ID number. _____

In making this written direction, we certify that the undersigned are all of the heirs of the deceased
S&T Telephone Cooperative member mentioned above and we will hold S&T Telephone Cooperative
Association harmless from any and all liability if such a check is issued as directed herein.

Name	Signature	Social Security #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(May be copied to be sent to lawful heirs.)

INDEMNIFICATION AGREEMENT

The Undersigned has/have requested from S&T Telephone Cooperative Association (“S&T”) early retirement and payment of the capital credits for the account in the name of _____, deceased (the “Deceased Member”).

The Undersigned has submitted a completed Affidavit of Information Concerning Deceased Member, and Written Direction to S&T Telephone Cooperative Regarding Capital Credits, as well as other requested information regarding the Deceased Member.

S&T is making distribution of the capital credits described herein to the Undersigned in reliance upon the representation by the Undersigned that the facts in the Affidavit of Information Concerning Deceased Member, and Written Direction to S&T Telephone Cooperative Regarding Capital Credits are true and complete and that the Undersigned is/are entitled to distribution of the capital credits in the Deceased Member’s account.

Accordingly, the Undersigned releases and forever discharges S&T and its representatives, agents and employees from all liability for capital credits due to the Undersigned from the Deceased Member’s account with respect to the funds distributed; and

The Undersigned agrees to indemnify S&T and hold S&T harmless from any claims, damages, costs and expenses (including attorneys’ fees and expenses) incurred by S&T and arising out of or based upon S&T’s distribution of the Deceased Member’s capital credits to the Undersigned, or any material misstatement or omission in the accompanying Affidavit of Information Concerning Deceased Member, and Written Direction to S&T Telephone Cooperative Regarding Capital Credits.

Name	Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***This agreement must be signed by all persons requesting any portion of the distribution listed on the Written Direction to S&T Telephone Cooperative Regarding Capital Credits**