CLAIM FOR DEATH BENEFITS

Pursuant to the Virginia Line of Duty Act

Administered by the

Office of the Comptroller
P.O. Box 1971
Richmond, Virginia 23218-1971

This form must be completed for each Line of Duty claim presented on behalf of a deceased public safety officer. The Virginia Line of Duty Act provides, **subject to certain conditions**, for a death benefit payment and a health insurance benefit to the beneficiary or beneficiaries of a public safety officer whose death is the direct result of, or is directly attributable to, service rendered to the Commonwealth or any of its political subdivisions. In order to determine the beneficiaries and their eligibility, the following information must be provided, pursuant to the Virginia Line of Duty Act, Section 9.1-400 through 9.1-402 of the Code of Virginia. Information presented here may also be disclosed to federal, local, or other state agencies. Failure to supply all of the requested information may result in a delay in processing this form and in the receipt of benefits. Please print or type.

Statute of Limitations: Pursuant to section 8.01-255 of the Code of Virginia, all claims must be submitted within the five year statutory period.

REPORT OF PUBLIC SAFETY OFFICER'S DEATH
(To be completed by employing agency)

1. Full Name and Address of Decedent

2. Social Security No.

3. Date of Birth

4. Date of Injury

5. Date of Death

6. Name and mailing address of employing agency, organization, or unit.

7. Officer's marital status at time of death:

☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Widowed

8. Name of Decedent's Supervising Officer

9. Supervisor's Telephone Number:
Phone number: ( )
E-mail Address:

10. At the time of injury, or death, was the officer performing in the line of duty?

☐ YES ☐ NO ☐ UNKNOWN

Decedent was employed as:

☐ Police Officer
☐ Corrections Officer (S 53.1-1)
☐ Va. National Guardsman
☐ Officer-Regulatory Div. (ABC)
☐ Firefighter
☐ Game Warden
☐ Forest Warden
☐ Dept. of Emergency Services Hazardous Materials Officer
☐ Other (specify)

In the service of:

☐ State Government
☐ Local Government
☐ Rescue Squad
☐ Fire Department
☐ Other (specify)

11. Officer's Employment Status when injury, or death occurred:

(a) ☐ Full Time
☐ Part time

(b) ☐ Compensated
☐ Volunteer

(c) ☐ On Duty
☐ Off Duty
☐ Retired
☐ Other (specify)

12. Date of Original Employment

13. Date of Retirement, if applicable

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REPORT OF PUBLIC SAFETY OFFICER'S DEATH
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14. Attach copies of the following applicable reports:

REPORTS	OTHER DOCUMENTATION (If applicable)
☐ Pre-Employment Physical Report	☐ Copy of certified list of volunteer firefighters, as recorded by the Clerk of the Court, if serving as a member of a Volunteer Fire Department (§ 27-42)
☐ Most Recent Medical/Physical Report	☐ Contract or Ordinance recognizing unit as part of a safety program (Applies to fire and rescue squad services - § 15.1-136.2)
☐ Coroner's Report	☐ Other (specify) _____
☐ Autopsy Report	
☐ Investigation Report	

IMPORTANT NOTE: It is the responsibility of the **employing agency** to provide the documents listed in Item 14 to the Virginia State Police. If the required documents are not received by the State Police, the application process will be delayed until the required documentation is received.

If the employing agency does not have the resources to provide any of the requested information, the agency must contact the Virginia State Police as soon as possible at 804-674-2062.

(NOTE: Please provide an explanation for the absence of any of the noted reports).

15. Was injury attributable to:

	Yes	No	Unknown
Officer's intentional misconduct?	☐	☐	☐
Officer's intent to bring about his own death?	☐	☐	☐
Officer's voluntary intoxication?	☐	☐	☐
Any person who may be entitled to benefit?	☐	☐	☐

(Attach explanation for each "yes" answer).

16. If known, provide the name and address of each witness to the officer's injury, if not provided in the reports requested in #14 above.

_____

_____

_____

_____

17. EMPLOYEE'S INSURANCE INFORMATION (NOTE : THIS IS REQUIRED INFORMATION AND IS NECESSARY IN ORDER FOR THE BENEFICIARIES TO APPLY FOR THE LINE OF DUTY HEALTH BENEFIT)

The health insurance benefits available under this Act will be **limited to state and local health insurance plans only**.

If the employee was not enrolled in a state, or local health insurance plan at the time of death, the insurance plan available will be the same state or local health insurance that the employee was entitled to on the last day of his/her active duty, or comparable benefits established as a result of a replacement plan.

If the employee was enrolled in a state or local health insurance plan at the time of his/her death, that coverage will be continued under the benefits provided by the Act. Please provide the deceased employee's current health insurance plan information below.

1) Name of the Insurance Company _____

2) Insurance Company Address: _____

_____

3) Insurance Company phone number: _____

4) Insurance Policy Number: _____

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5) Provide the following information for all individuals who are covered under this policy:

	Full Name	Social Security Number	Address	Relationship
1)				
2)				
3)				
4)				
5)				

(If additional space is needed, please attach a separate sheet of paper with the required information.)

6) Is this a State or Local Plan? (check one) State ☐ Local ☐

7) What was the monthly cost of this insurance plan to the employee? _____

8) Did the employer pay a portion of the insurance cost? If your answer is Yes, please provide the amount that is paid by the employer each month
Yes ☐ Employer Paid _____ per month No ☐

9) Provide the name of the contact at the employer's office who can answer any questions we may have regarding the insurance plan.:

Name: _____ Phone Number: _____ E-mail address: _____

18. EMPLOYING ORGANIZATION

_____

All information presented here is true to the best of my knowledge and belief.

_____ _____
Signature of Person Providing Above Information Typed or Printed Name and Title

Phone Number: ( )_____ Date: _____

E-mail Address: _____

19. NOTARY INFORMATION

_____

Notarized Date: _____

Notary Public Signature: _____

My commission expires on: _____

CLAIM OF DEATH BENEFITS
(To be completed by Claimant)

REQUIRED INFORMATION FOR APPLICATION OF THE LINE OF DUTY DEATH BENEFIT

Did Decedent Leave a will? ☐ Yes ☐ No

(**If yes**, please attach a copy of the **PROBATED WILL**.)

A. SURVIVING SPOUSE This section must be completed when decedent is survived by a spouse.

NOTE: Attach a copy of each applicable item of documentation, such as Marriage certificate, divorce decree, or separation agreement.

1. Name (last, first, middle)

2. Mailing Address

3. If married, was decedent married to anyone else prior to this marriage?

☐ NO ☐ YES

4. If yes, are there any children from a previous marriage?

☐ NO ☐ YES

If yes, provide the required information for each child below in Section B. SURVIVING CHILDREN

B. SURVIVING CHILDREN: This part must be completed to include each child if decedent is survived by natural, adopted, illegitimate, or stepchildren, or posthumous child (ren).

1. NAME (last, first, middle)	Relationship	Date of Birth	Address

(Please attach a copy of the birth certificate for each child)

2. If a legal guardian has been appointed for any of the above-mentioned children, please complete this section and provide applicable legal guardianship documents.

NAME OF GUARDIAN (S)	ADDRESS	NAME OF CHILD

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C. OTHER CLAIMANTS If there is no surviving spouse or child(ren), this section must be completed by all other claimants (i.e., grandchildren, CLAIMANT(S) parents, brothers, sisters, nieces, nephews, etc.).

	NAME (last, first, middle)	RELATIONSHIP	MAILING ADDRESS
1.			

REQUIRED INFORMATION FOR APPLICATION OF THE HEALTH INSURANCE BENEFIT

A. DEPENDENTS:

1) GENERAL INFORMATION: These are the general requirements for a child to be considered a dependent for the purposes of this benefit (Items 1) A) through 1) c). Further detailed requirements are listed in items 2) through 8) below. In addition, please refer to the Virginia Line of Duty Act which can be found in **Section 9.1-400 through 9.1-402 of the Code of Virginia.**

A) the child is under the age of 21, **AND** is **NOT** married, **AND** is **NOT** covered under an alternate health insurance plan
B) the child is a full-time college student under the age of 25
C) the child is over 21, but is mentally or physically disabled

2) CHILDREN WHO MEET THE REQUIREMENTS ABOVE, BUT ARE NOT CONSIDERED TO BE A DEPENDENT BY THE DECEASED EMPLOYEE: Any child (children) that is conceived by the spouse (or ex-spouse) of the deceased employee, but was not considered a dependent per the wishes of the deceased employee, will NOT be considered a dependent for the purposes of this benefit. Please refer to the 2 examples below.

Example 1) An ex-spouse of the deceased employee becomes re-married to someone other than the deceased employee, and has a child born of that marriage. That child will NOT be covered by the health benefits available under this Act.
Example 2) A child is born to the spouse of the deceased employee, and was not considered a dependent by the deceased employee. That child will NOT be covered by the health benefits available under this Act.

3) TERMINATION OF DEPENDENT COVERAGE: Continued health insurance provided by this benefit shall terminate upon the occurrence of any one of the following situations:

1) the dependent's death,
2) the dependent marries,
3) the dependent is covered by an alternate health insurance plan, or
4) the dependent turns 21 years of age AND is NOT mentally or physically disabled **OR** is NOT enrolled as a full-time college student. (NOTE: Dependents age 21 or more may be covered, if they meet full-time college student eligibility requirements, Please see the section below entitled "FULL-TIME COLLEGE STUDENT'.)
5) the dependent is 21 or older, was deemed a full-time student during the application process and has ceased to be a full-time student
6) the dependent is a full-time college student and reaches the age of 25

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4) DEFINITION OF "DEPENDENT: The term "dependent" applies to those persons who were dependent on the deceased employee. This definition would normally include the deceased employee's children, including those who are born after the employee's death. Children of a deceased employee's divorced spouse who later remarries and subsequently had children from the other marriage should not be considered as dependents of the deceased employee.

5) DEFINITION OF "CHILD": The term "Child" applies to the following list: natural child, adopted child, illegitimate child, or stepchild.

6) DEFINITION OF "FULL-TIME COLLEGE STUDENT": A student is considered a full-time college student, if he or she is enrolled with a minimum of 12 semester credit hours at a college.

7) DEFINITION OF "COLLEGE": For the purposes of this benefit, accredited colleges and universities only will qualify.

8) FULL-TIME COLLEGE STUDENT DEPENDENT INFORMATION: The following information is required of any dependent who is considered a full-time college student for the purposes of claiming benefits under the Act:
   A) the name, address and phone number of the college the dependent is currently enrolled, along with the anticipated graduation date.
   B) any change in the student's college enrollment status will be communicated to the Comptroller's office
   C) if the student becomes enrolled in a college other than the one noted on this application, the Comptroller's office will be notified.

9) COLLEGE INFORMATION:

NAME and ADDRESS OF COLLEGE: _____

COLLEGE PHONE NUMBER: _____

ANTICIPATED DATE OF GRADUATION: _____

10) DEPENDENT'S INFORMATION

CHILD'S NAME (last, first, middle)	Relationship	Social Security Number	Date of Birth	Address

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(To be completed by Claimant)

NOTE: CERTIFICATION AND NOTARY INFORMATION IS REQUIRED FOR BOTH THE DEATH BENEFIT AND THE HEALTH INSURANCE BENEFIT

B. CLAIMANT'S CERTIFICATION

I hereby submit my claim for benefits on my behalf, or on behalf of other eligible beneficiaries (as indicated), pursuant to the Virginia Line of Duty Act. All information presented here is true to the best of my knowledge and belief.

I understand that a false answer to any question in this statement may be grounds for nonpayment of benefits. All information will be considered in reviewing the claim and is subject to investigation.

In reference to health insurance benefits, my signature below serves as certification that:

1) any dependents requesting health benefits under this Act are not older that 21 years of age
2) if the dependent is over 21, the dependent is a full time college student or is physically and mentally disabled
3) if the dependent is a full time college student, he or she is not older than 25 years of age
4) the Comptroller's office will be notified immediately of any change in the claimants and other beneficiaries' physical, marital or dependent status
5) the Comptroller's office will be notified immediately of any change in the claimants and other beneficiaries' address and phone number.
6) the Comptroller's office, the Department of Human Resource Management, and the Virginia State Police have my permission to contact the deceased employee's employer with any questions regarding the current insurance plan.

_____ _____

Signature of Claimant — Typed or Printed Name of Claimant

(If the dependent is a minor claimant, his or her parent must sign.)

_____

Signature of Spouse

Phone Number: ( )_____ Date: _____

E-mail address: _____

C. NOTARY INFORMATION

Notarized Date: _____

Notary Public Signature: _____

My commission expires on: _____

D. SUBMISSION OF FORM

This form must be completed in its entirety. If any of the requested information is not applicable to you, please make a note of this in the appropriate places. Please ensure that all appropriate signatures are obtained and that copies of all requested documents are attached. Failure to provide the requested information will result in a delay in the processing of the claim. Upon completion, this form must be submitted to:

If a local police or sheriff's department doing investigation:

Department of State Police
Personnel Relations Department
P. O. Box 27472
Richmond, Virginia 23261-7472

OR

Department of Accounts
Attn: Line of Duty
P. O. Box 1971
Richmond, Virginia 23218-1971

The Line of Duty Claim form will then become a part of the Official State investigation.

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