CLAIM FOR DISABILITY BENEFITS

Pursuant to the Virginia Line of Duty Act

Administered by the

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

Submit claim form to

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

This form must be completed for each Line of Duty disability claim presented on behalf of a disabled public safety officer. The Virginia Line of Duty Act provides, subject to certain conditions, for a health insurance benefit payment for the beneficiary and/or beneficiaries of a public safety officer whose disability 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: *Claims will be accepted for review for qualified individuals who become disabled* ***on or after July 1, 2000 and for qualified state employees who became disabled on or after April 8, 1972****. 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 DISABILITY
(To be completed by employing agency)

1. Name:

   Address:
   City:
   State: Zip:

2. Social Security No. 3. Date of Birth

4. Date of Disability

5. (a) State employee ☐ YES ☐ NO

   (b) Name and mailing address of employing agency, organization, or unit.

6. Officer's marital status at time of disability:

   ☐ Single ☐ Married
   ☐ Separated ☐ Divorced
   ☐ Widowed

7. Name of Disabled Employee's Supervising Officer

8. Supervisor's Telephone Number
   Email Address:

9. At the time of disability, was the officer performing in the line of duty?

   ☐ YES ☐ NO ☐ UNKNOWN

11: Employee is 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)

_____

10. Officer's Employment Status when disability 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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14. Attach copies of the following applicable reports.

REPORTS and OTHER DOCUMENTATION (If applicable)

- ☐ Insurance Rate Sheets covering the Period from the date of the Claimant's last day of active duty to present
- ☐ Disabled Employee Pre-Employment Physical Report
- ☐ Disabled Employee's Most Recent Medical/Physical Report
- ☐ Letter from Disabled Employee's Physician stating the reason for the disability and expected duration
- ☐ VRS "Physician's Report" of disability, form VRS-6b (or, a similar report, if VRS is not the locality's retirement system)
- ☐ 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 (S 27-42)
- ☐ Contract or Ordinance recognizing unit as part of a safety program (Applies to fire and rescue squad services - S15.1-136.2)
- ☐ Investigation Report of Incident that led to the Disability
- ☐ Marriage Certificate (if applicable)
- ☐ Birth Certificates of all children (if applicable)
- ☐ Other (specify)

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 disability attributable to:

	Yes	No	Unknown
Officer's intentional misconduct?	☐	☐	☐
Officer's intent to bring about his own disability?	☐	☐	☐
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 incident that led to the officer's disability, if not provided in the reports requested in #14 above.

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17. EMPLOYEE'S INSURANCE INFORMATION

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

If the disabled employee was not enrolled in a state, or local health insurance plan at the time of the disability, the insurance benefits available will be the same state or local health insurance that the disabled 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 disabled employee was enrolled in a state or local health insurance plan at the time of his/her disability, the Act provides benefits for continued coverage. Please provide the disabled employee's health insurance plan information at the time of his/her disability below.

1) Name of Insurance Plan: _____ Name of Dental Plan: _____

Name of Vision Plan: _____ Out Network Coverage: _____

2) Insurance Company Name: _____

3) Insurance Company Address: _____

_____

5) Insurance Company phone number: _____ Insurance Policy Number:_____

6) **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 is the monthly cost of this insurance plan to the disabled employee? _____

8) Does the employer pay a portion of the insurance cost? If the answer is Yes, please provide the amount that is paid by the employer each month.
1) Yes ☐ Employer Pays_____ per month 2) No ☐

9) What is the total monthly cost of this insurance plan? _____

10) 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: _____

Mailing address: _____

Department (i.e. payroll, human resources): _____

A COPY OF THE INSURANCE RATE SHEET SUPPORTING THE MONTHLY INSURANCE COST (Item 9) MUST BE PROVIDED BY THE EMPLOYING AGENCY.

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18. EMPLOYING ORGANIZATION CERTIFICATION

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 FOR DISABILITY BENEFITS
(To be completed by Claimants)

A. SPOUSE: **Please provide the required information for the spouse of the disabled employee.**

1) Spouse's Name (last, first, middle) _____

2) Mailing Address (with ZIP) _____

_____

_____

3) Spouse's Social Security Number: _____

4) GENERAL ELIGIBILITY: In order for the spouse of a disabled person to be considered eligible for this benefit, he/she must have been married to the disabled individual at the time of his/her disability.

5) SPOUSAL ELIGIBILITY EXCLUSIONS:

1) The spouse of a disabled person is **NOT** married to the disabled person at the time of the disability.
2) The spouse of a disabled person as of the disability date is subsequently divorced from the disabled person.
3) The spouse becomes covered by an alternate health insurance plan from the plan in force as of the disability date.

B. DEPENDENTS:

1) GENERAL ELIGIBILITY: These are the general requirements for a child to be considered an eligible dependent for the purposes of this benefit. 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
D) the child is born prior to the disability date

2) DEPENDENT ELIGIBILITY EXCLUSIONS: Children who become dependents of the disabled person after the disability date, whether through birth, adoption, or marriage, or other means are not eligible for this benefit.

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 dies,
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 older 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

4) DEFINITION OF "DEPENDENT: The term "dependent" applies to those persons who are shown to be financially and legally dependent on the disabled person as of the disability date. This definition would normally include the disabled person's children including natural children, adopted children, stepchildren and children born out of wedlock.

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(To be completed by Claimants)

5) DEFINITION OF "CHILD": The term "Child" applies to the following list: natural child, adopted child, children born out of wedlock, 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, only accredited colleges and universities 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 this 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

CLAIM FOR DISABILITY BENEFITS
(To be completed by Claimants)

D. 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.

My signature below serves as certification that:

1) the Comptroller's office will be notified immediately of any change in the claimants and other beneficiaries' physical, marital, dependent, or insurance coverage status
2) the Comptroller's office will be notified immediately of any change in the claimants and other beneficiaries' address and phone number.
3) the Comptroller's office, the Department of Human Resource Management, and the Virginia State Police have my permission to contact my employer with any questions regarding my 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: _____

E. NOTARY INFORMATION

Notarized Date: _____

Notary Public Signature: _____

My commission expires on: _____

F. **SUBMISSION OF FORM**

This form must be completed in its entirety. 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:

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

The Line of Duty Claim form will then become a part of the Official State Police investigation report and will be submitted to the Comptroller for review upon completion of the investigation.

(Rev 6/05)