Approved OMB No. 1121-0024 (Expires: 04/30/2007)

U.S. DEPARTMENT OF JUSTICE
OFFICE OF JUSTICE PROGRAMS
BUREAU OF JUSTICE ASSISTANCE
PUBLIC SAFETY OFFICERS BENEFITS PROGRAM
WASHINGTON, D.C. 20531

CLAIM FOR DEATH BENEFITS

FOR DOJ USE ONLY

CASE NUMBER _____

DATE RECEIVED _____

This form should be filed by a surviving spouse, child/children, insurance beneficiary and/or parent(s) of the deceased public safety officer. This claim may be prepared by someone on behalf of these individuals. If you are filing on behalf of others, you must attach evidence of your authority to do so. **PLEASE PRINT PLAINLY OR TYPE**

1. NAME OF OFFICER (Last, First, Middle)		2. OFFICER'S TITLE
3. SOCIAL SECURITY NUMBER	4. DATE OF INJURY	5. DATE OF DEATH

6. NAME AND PHYSICAL ADDRESS OF EMPLOYING AGENCY, ORGANIZATION OR UNIT IN WHOSE SERVICE DEATH OCCURRED (Include zip code)

INSTRUCTIONS: To ensure payment to all eligible individuals, attach valid documentation (such as notarized, certified, or attested to documentation) regarding marriage, divorce, separation decrees, death certificates, birth certificates, adoption papers, custody agreements, or other evidence of parent-child relationship, as appropriate for any claimant in Parts I and II

PART I INFORMATION ON SURVIVING BENEFICIARY

If at the time of an officer's death the officer was survived by a husband, wife, or parent(s), Part I should be completed. If there are children of the officer, regardless of age or dependency, Part II must be completed. (Attach certified copies of marriage license, all divorce decrees (including custody agreements), or separation agreements as applicable to martial relationship with the officer and certified copies of children's birth certificates.) If the decedent is survived by neither spouse nor eligible child, provide a copy of the officer's most recent life insurance policies. **PLEASE NOTE:** The decedent's employing agency will be asked to provide departmental insurance policies.

7. ELIGIBLE BENEFICIARY Spouse ☐ Mother ☐ Father ☐ Other beneficiary ☐

NAME (Last, First, Middle)	SOCIAL SECURITY NO.
MAILING ADDRESS (Include zip code)	
NAME (Last, First, Middle)	SOCIAL SECURITY NO.
MAILING ADDRESS (Include zip code)	

8. MARITAL STATUS OF OFFICER AT TIME OF DEATH.

MARRIED ☐ SINGLE ☐
SEPARATED ☐ OTHER ☐_____
DIVORCED ☐ (Please identify)

Attach necessary documentation such as marriage certificates, all divorce decrees and custody agreements, or separation agreements.

9. DO YOU HAVE REASON TO BELIEVE THAT THE OFFICER WAS MARRIED AT ANY TIME TO ANYONE ELSE?

YES ☐ NO ☐ UNKNOWN ☐

If yes, please list number of marriages and submit documents to show dissolution of prior marriages, such as death certificates or divorce decrees. _____

9a. List number of times surviving spouse was previously married. _____

10. DO YOU HAVE REASON TO BELIEVE THAT THE OFFICER HAD A CHILD(REN) FROM A PREVIOUS MARRIAGE OR RELATIONSHIP?

YES ☐ NO ☐

If yes, include in Part II or explain on a separate sheet of paper and attach to this form.

PART II SURVIVING CHILDREN INFORMATION

If the officer was survived by a natural, out-of-wedlock, adopted or posthumous child, or stepchild (or children) at the time of death, complete this part. All surviving children should be listed regardless of age or dependency status at the time of the officer's death. Attach a certified copy of birth certificates, adoption papers, DNA results, or other evidence of parent-child relation, as appropriate.

11. NAME (Last, First, Middle Initial)	Date of Birth	Social Security No.	If over 18, educational status at the time of parent's death	Marital Status regardless of age
			Full-Time ☐ Part-Time ☐ N/A ☐	Married ☐ Single ☐

Address (if different from item 7, above) and Telephone Number	PARENT OR LEGAL GUARDIAN NAME & SOCIAL SECURITY NUMBER

PART II CONTINUED

11. NAME (Last, First, Middle Initial)	Date of Birth	Social Security No.	If over 18, educational status at the time of parent's death	Marital Status regardless of age
			Full-Time ☐ Part-Time ☐ N/A ☐	Married ☐ Single ☐
Address (if different from item 7, above) and Telephone Number		PARENT OR LEGAL GUARDIAN NAME & SOCIAL SECURITY NUMBER		

11. NAME (Last, First, Middle Initial)	Date of Birth	Social Security No.	If over 18, educational status at the time of parent's death	Marital Status regardless of age
			Full-Time ☐ Part-Time ☐ N/A ☐	Married ☐ Single ☐
Address (if different from item 7, above) and Telephone Number		PARENT OR LEGAL GUARDIAN NAME & SOCIAL SECURITY NUMBER		

11. NAME (Last, First, Middle Initial)	Date of Birth	Social Security No.	If over 18, educational status at the time of parent's death	Marital Status regardless of age
			Full-Time ☐ Part-Time ☐ N/A ☐	Married ☐ Single ☐
Address (if different from item 7, above) and Telephone Number		PARENT OR LEGAL GUARDIAN NAME & SOCIAL SECURITY NUMBER		

Please attach a separate sheet of paper if there are additional children.

PART III

STATEMENTS AND CLAIM: All claimants are required to complete this Part. The purpose of this claim is to establish survivorship eligibility and assert the rights to benefits under the Omnibus Crime Control and Safe Streets Act of 1968, as amended (42. U.S.C. 3796). The filing of this claim does not constitute a determination by the Department of Justice that benefits will or will not be awarded to the claimant(s).

This claim may be prepared by a person acting on behalf of the claimant(s) such as a parent, legally appointed guardian, other legal representatives, or duly designated representatives of the claimant(s). Evidence of authority to represent claimant(s) should be attached.

A. **STATEMENT ON OTHER CLAIMS FILED WITH THE UNITED STATES GOVERNMENT AND/OR THE DISTRICT OF COLUMBIA:**

Has claim been filed for benefits under

(1) Federal Employees Compensation Act, Section 8191 title 5, U.S. Code? YES ☐ NO ☐

(2) D.C. Retirement and Disability Act of September 1, 1916, Section 4-622? YES ☐ NO ☐

B. STATEMENT OF FINANCIAL NEED: If an immediate financial hardship has been incurred as a result of this death, an interim payment of $3000 may be made. If you are experiencing an immediate financial hardship, please attach a statement of financial circumstances and need. This statement must include all financial responsibility, all benefits that you are eligible for, and the benefits that you have received to date. If all documents required to complete this claim are received an interim payment may not be necessary.

This form will be used by the Department of Justice to determine eligibility of a claimant for paying death benefits. The information may be disclosed to Federal, State, and local agencies to verify eligibility for benefits. We must have Social Security Numbers to process payments.

I certify that the above information is correct and complete to the best of my knowledge. I certify further that I am not aware of any potential claimant for this PSOB death benefit other than those listed above. I know of no facts or circumstances that would render the above-listed persons ineligible for this benefit. I understand that a false or incomplete statement or a failure to fully disclose pertinent information concerning this claim may be grounds for non-payment of benefits or for prosecution for a false statement under 18 U.S.C. § 1001.

All the information you give will be considered in reviewing the claim and is subject to investigation.

SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE (If representative, provide claimant's affidavit granting power of attorney)		DATE
		E-MAIL (If available)
Home number. (Including Area Code)	Work number (Including Area Code)	Alternate number (Including Area Code)

Public Reporting Burden

Paper Reduction Act Notice. Under the Paperwork Reduction Act, a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you to provide us with information. The estimated average time to complete and file this application is 90 minutes per application. If you have comments regarding the accuracy of this claim, or suggestions for making this claim form simpler, you can write to the Public Safety Officers' Benefits Program, Bureau of Justice Assistance, 810 7th Street, NW, Washington, D.C. 20531 and to the Office of Information and Regulatory Affairs, Office or Management and Budget, Washington, D.C. 20530.