

CLAIM FOR DEATH BENEFITS – KRS 61.315  
 Department of Corrections 501 KAR 15:020  
 (To be completed by family of deceased)

**FOR OFFICIAL USE ONLY**

CASE NO.:	
DATE RECEIVED:	

Name of Deceased (last, first, middle):	Social Security No.:	Date of Injury:	Date of Death:
---	----------------------	-----------------	----------------

Name and address of public safety agency, organization or unit in which service death occurred:

**INSTRUCTIONS:** A claim should be filed when an eligible correctional employee has died of a personal injury sustained in the line of duty. **WHO SHOULD FILE:** (1) Surviving Spouse (Complete Part 1), (2) Child or Children of the Deceased (Complete Part 2I), or (3) Parent or Parents of the Deceased (Complete Part 3). Where documentation is required, a properly certified copy of the record will suffice. See 501 KAR 15:020.

**PART 1:**  
 INFORMATION ON SURVIVING SPOUSE

When at the time of the employee's death, they were survived by a husband or wife, this part should be completed. Please attach marriage certificate.

Name of Spouse ( <i>first, middle, last, maiden</i> ):	Social Security No.:
--	----------------------

Mailing Address:	Email Address:	Phone No.:
------------------	----------------	------------

Was the employee previously married to anyone other than current spouse else? ( <i>please select one</i> ) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <i>If answer is yes, submit documents to show dissolution of prior marriage.</i>	Does deceased employee have any children from a previous marriage or relationship? ( <i>please select one</i> ) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown <i>If answer is yes, include under Part 2 or explain on separate sheet and attach to this form.</i>
--	--

**PART 2:**  
 INFORMATION ON CHILDREN

If the employee was survived by a natural, adopted, or \*posthumous child this part should be completed. Attach copy of birth certificates, adoption papers, or other evidence of parent-child relationship, as appropriate. See 501 KAR 15:020.

Child's Full Name:	Social Security No.:	Date of Birth:	Mailing Address :	Telephone No.:

\*an infant born following the death of the father or mother.

Has a legal guardian been appointed for any of the above mentioned children?  Yes  No  Unknown  
 (If yes, give name and mailing address of guardian of each child.)  
 (Legal guardianship documents will be required in the event benefits will be awarded to children under guardianship.)

Guardian(s) Name:	Social Security No.:	Mailing Address:	Guardian For (list children's names):	Phone No.:

**PART 3:**  
 PARENT(S) OF EMPLOYEE  
 If at the time of death the employee was not survived by a spouse or children and there is a parent or parents of the deceased, this part should be completed. Attach a copy of the employee's birth certificate or other evidence of parent-child relationship as appropriate. See 501 KAR 15:020.

Parent(s)-claimant(s) in circumstance of no surviving spouse or children			
Full Name:	Social Security No.:	Mailing Address:	Telephone No.:

I hereby make claim for compensation for myself as, or on behalf of, spouse, child/children or other eligible claimants listed above, as a result of the death of the above named employee who sustained fatal injury in the line of duty. Every statement and information set forth herein is true to the best of my knowledge and belief.

A false answer to any question in this statement may be grounds for non-payment of benefits and may be punishable by fine or imprisonment. All the information you give will be considered in reviewing the claim and is subject to investigation.

Signature of Claimant or Authorized Representative		Date:
Mailing Address:	Phone No.:	Email Address:

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.

Mail completed form to:  
 Office of the Commissioner  
 Department of Corrections  
 PO Box 2400  
 Frankfort, KY 40602-2400