CLAIM FOR DEATH BENEFITS – KRS 61.315

(To be completed by law enforcement agency of deceased)

FOR CABINET USE ONLY

CASE NO.:	
DATE RECEIVED:	

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

PART 1:

NOTICE OF LINE OF DUTY DEATH OF POLICE OFFICER

Name of deceased police officer *(last, first, middle)*:	Social Security No.:	Date of Injury:	Date of Death:

Deceased police officer’s last mailing address:

Name of decedents superior officer:	Telephone No.:

Was injury contributed to by:	**YES** *Attach explanations for any yes answers.*	**NO**	**UNKNOWN**
Police officer's prior disease or injury?			
Police officer's intentional misconduct?			
Police officer's willful or wanton disregard?			
Police officer's intent to bring about his own death?			
Police officer's voluntary intoxication?			
Any person who may be entitled to benefit?			

Provide proof of wage payments, amounts and last pay period dates

Police officer’s employment status when injury occurred*:*	Full-Time:	Part-Time:	Volunteer:	Other *(please explain)*:

Part 2:

PLEASE CHECK AND ATTACH ALL APPLICABLE REPORTS RELATING TO THE DIRECT CAUSE OF/OR PROXIMATE CAUSE OF DEATH. SEE 500 KAR 1:010 – 500 KAR 1:030.

Certified copy of original reports attached *(check all that apply)*:

Medical Report *(attending physician)*	Autopsy Report	Death Certificate	Coroner’s Report	Investigation Report

Other *(please explain)*:

If no investigation report exists, please provide statement of circumstances leading to death. Please attach additional pages, if needed.

If known, give name and address of witness(es) with whom police officer was involved when injured, if not provided in the above reports:

Witness(es):	Mailing address:	Phone No.

Part 3:
INFORMATION CONCERNING POSSIBLE CLAIMANTS

Name of claimant:	Relationship to deceased officer:	Birthdate of claimant:	Social Security No. of claimant:	Mailing address of claimant:	Phone No. of claimant:

List surviving parents only when neither spouse nor children survive decedent.

Part 4: CERTIFICATIONS 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.		
Employing Organization - To the best of my knowledge and belief, the above stated information is true and complete.		
Name and Title:	Organization:	Date:
Mailing address:	Phone No.:	Email address:
Signature:		

MAIL COMPLETED FORM TO:

Justice and Public Safety Cabinet, Death Claims Administrator
c/o Asst. General Counsel, DOCJT
521 Lancaster Avenue
Funderburk Building
Richmond, KY 40475