CLAIM FOR HEALTH INSURANCE 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 HEALTH INSURANCE BENEFIT claim presented on behalf of a deceased public safety officer's beneficiary and/or dependents. In addition to the death benefit payment, The Virginia Line of Duty Act provides, **subject to certain conditions**, for 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 eligibility of the beneficiaries, 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.

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.

1. Full Name and Address of Applicant:	2. Applicant Social Security Number: 3. Applicant Phone number: (H) (W) 4. Applicant E-mail address (if applicable):
5. Full Name of Deceased Employee:	6. Deceased Employee Social Security Number:
7. Deceased's Former Employer Information: Name: Address: Federal ID number:	8. Former Employer Human Resource or Payroll contact: Name: Mailing address: Phone:

General Instructions:

1) Please print or type.
2) Read all information regarding "Dependents" very carefully prior to filling out the application.
3) Fill in all applicable information.
4) If there is an area that does not apply to you, please indicate this by writing "N/A" in the field.
5) Sign and Date the application.
6) Have the completed application Notarized.
7) Important: Include a copy of the letter from the Comptroller's office, stating approval of the death claim, along with this application.
8) Mail the completed application to the Department of Accounts at the address shown on the last page of the form.

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A. Dependents:

1) **General Information:** Listed below are the **general requirements** for a child to be considered a dependent for the purposes of this benefit. [See Items 1) A) through 1) C) below]. 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.**

   General Requirements:
   - 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) **Information for children who were NOT considered a dependent by the deceased employee:** Although some children may meet the requirements shown in Item 1) above, that child may not have been considered a dependent of the deceased employee. In that case, 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**:

   A) the dependent's death,
   B) the dependent marries,
   C) the dependent is covered by an alternate health insurance plan, or
   D) 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 for D): 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".)
   E) 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
   F) the dependent is a full-time college student and reaches the age of 25

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A. Dependents (continued)

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.

   Note: 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 this Act.
   A) The name, address, and phone number of the college the dependent is currently enrolled, along with the anticipated graduation date. (See Item 9 below)
   B) Changes in the student's college enrollment status will be communicated to the Comptroller's office immediately.
   C) If the student becomes enrolled in a college other than the one noted on this application, the Comptroller's office will be notified immediately.
   D) Submit proof of college enrollment with this application.

9) **College Information**:

   Name and Address of College:

   _____

   _____

   _____

   College Phone Number: _____

   Anticipated Date of Graduation: _____

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A) Dependents (continued)

10) Dependent's Information ******:

Child's Name (last, first, middle)	Relationship to Deceased	Social Security Number	Date of Birth	Address

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B. SPOUSES (Applicant's) INSURANCE INFORMATION

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

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

If the deceased 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 applicant'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: _____
5) Is this a State or Local Plan? (check one) State ☐ Local ☐ Neither ☐
6) What is the monthly cost of this insurance plan to the applicant? _____
7) Does the deceased's 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
   1) Yes ☐ Employer Pays_____ per month 2) No ☐
8) Provide the name of the contact at the deceased employer's office who can answer any questions we may have regarding their insurance plan.
   Name:_____ Phone Number: _____
   E-mail address: _____ Mailing address: _____
   Department (i.e., payroll, human resources, etc.): _____
9) ******Amount paid by applicant for health insurance premiums since July 1, 2000? _____
10) ******Amount paid by deceased employer's office for applicant's health insurance premiums since July 1, 2000? _____

**** Important: For Items 9 and 10, please provide proof of amounts paid (i.e., cancelled checks, insurance company statement, information from the locality/state human resource department, etc.)**

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C. Claimant's Certification:

Note: Certification and notary information is required. Failure to do so will delay the review process.

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 or guardian must sign.)

Phone Number: Date:

E-mail address:

D. Notary Information

Notarized Date: _____
Notary Public Signature: _____
My commission expires on: _____

D) Submission of Form

Reminders:

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

Mailing address: Upon completion, this form must be submitted to:
Departmnt of Accounts
Attn: Line of Duty Coordinator
P.O. Box 1971
Richmond, Virginia 23218-1971

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.

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