



**Officer/Firefighter Line of Duty Death
POTENTIAL BENEFITS REQUEST FORM**

REQUIRED INFORMATION:

Date of Death: _____ Line of Duty? Yes / No Years of Service: _____ Today's Date: _____

Name of Deceased: _____ Birth Date: _____

Title/Position: _____

Spouse Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Mobile Phone: () _____

Other Phone: () _____ Email: _____

Make Benefit Check To: _____

DEPENDENTS (other than spouse): _____ Approximate Age: _____

_____	_____
_____	_____
_____	_____
_____	_____

INFORMATION PROVIDED BY:

Name: _____ Title: _____

Office Phone: () _____ Mobile Phone: () _____

Fax Number: () _____ Email: _____

Department/Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature of Agency Head approving this Request: _____ Title: _____

EVENT OF DEATH: (Provide who, what, when, where, how. Include reports, articles, if available.)

TO BE COMPLETED BY AUTHORIZED 100 CLUB PERSONNEL:

Approved: _____ Date: _____ Check #: _____ Amount: _____