

**APPLICATION FOR SURVIVOR BENEFITS
(SERVICE-CONNECTED DEATH)**

To claim survivor benefits for which you may be eligible, complete this application in its entirety and return it to LACERA in the enclosed reply envelope. (You may attach an additional sheet if more space is needed.) If you have questions on how to complete this form, call LACERA at 1-800-786-6464.

Date of Application: _____

DECEASED MEMBER INFORMATION (please print)

Name: _____

Social Security No.: _____ Date of Death: _____

County Department: _____ Job Title: _____

SURVIVOR MEMBER INFORMATION (please print)

Name: _____ Phone: _____

Social Security No.: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

1. Describe specifically the injury or illness you claim caused the death.

2. Where and when did the injury or illness occur? (Include approximate date.)

3. How did the injury occur, or what caused the onset of the illness? (Please answer completely.)

4. Was the cause of death the result of a job-related injury or illness? Yes No

If Yes, give names, work locations, phone numbers, and addresses of any witnesses.



5. Are you claiming the deceased member's job or job environment accelerated or aggravated a pre-existing injury or illness? Yes No If Yes:

a. What was the nature of the preexisting injury?

b. Give the date of the original occurrence of the preexisting injury or onset of the illness:

6. a. List the names, addresses, and telephone numbers of all doctors, hospitals, or clinics consulted for diagnosis or treatment relating to the injury or illness. Include approximate dates of consultation, if known. (Attach page if necessary.)

b. If the decedent was treated at Kaiser (S.C.P.M.G.), please list the location and address of the facility
Please include Kaiser Medical Record No.

c. Has a Workers' Compensation claim been filed for this or any other injury or illness? Yes No
If Yes, state the date(s) the application(s) was(were) filed, if known.

7. Include any additional information you wish the Board of Retirement to consider in determining your eligibility.

8. Will you be represented by an attorney in this application process? Yes No If Yes:

Attorney's Name: _____

Firm Name: _____

Address: _____

Phone No: _____

<p>▶ I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge.</p> <p>Survivor Signature X _____ Date: _____</p>
