



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:

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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.

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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: \_\_\_\_\_

**▶ I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge.**

Survivor Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_