

**CLAIMS AGAINST THIRD PARTIES
(SERVICE-CONNECTED DEATH)****THIS FORM MUST BE COMPLETED IF YOU ARE APPLYING FOR A DISABILITY RETIREMENT**

Please read the entire form then complete either Section 1 or Section 2, whichever applies, and complete Section 3.

SECTION 1

I certify that the death of _____ (name of deceased) is not a result of, or caused by, or connected to, in any manner, an injury or illness that involves a third party (i.e., someone or an organization other than your County/District employer).

_____ Please initial here and complete Section 3.

SECTION 2

If the death of _____ (name of deceased) involves a third party, please provide the following information:

Name of Third Party: _____ Phone No.: _____

Address: _____

City: _____ State: _____ ZIP: _____

Description of how the injury or illness occurred, including third party's involvement.

Was a claim of any type filed against the third party named above?

 Yes No

Case Name: _____ Case No.: _____ Date Filed: _____

If No, do you plan to file a claim in the future?

 Yes No If No, please tell us why:**SECTION 3**I, the undersigned, agree to notify LACERA if I file any type of claim against a third party, whether or not named above, for the injury or illness resulting in the death of _____
(Name of Deceased)

Decedent's Social Security No.: _____ Date: _____

Print Survivor's Name: _____ Survivor's Signature: _____

