

**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: \_\_\_\_\_

