CLAIM FOR STATE EMPLOYEE LINE OF DUTY DEATH BENEFIT FOR A SPOUSE, OR DEPENDENT CHILD AS BENEFICIARY

State Form 55761 (R5 / 12-24)

INDIANA PUBLIC RETIREMENT SYSTEM
STATE EMPLOYEE DEATH BENEFIT FUND
One North Capitol Avenue, Suite 001
Indianapolis, IN 46204-2014
Telephone: (844) GO-INPRS (Toll-free)
Fax: (866) 591-9441 (Toll-free)
E-mail: questions@inprs.in.gov
Web site: www.inprs.in.gov

* This agency is requesting disclosure of Social Security numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory and this form cannot be processed without it.

INSTRUCTIONS

1. Read this form completely before entering information. Include an English translation of all foreign documents.
2. Remove any instruction pages included with this form prior to returning the completed form to the Indiana Public Retirement System (INPRS) at the address shown above.
3. Type or print using black ink. Complete all information and place the State Employee's name, Social Security number and Pension ID number at the top of each page and on any additional pages of information being submitted.
4. Dependent child/children are defined by statute as dependents claimed on the federal income tax returned filed by the State Employee in the year before the year in which the State Employee died (IC 5-10-11-5(b)).
5. If you are filing this claim as guardian of a dependent child/children include documentation establishing your guardianship such as Letters of Guardianship or a court order.
6. This completed, signed, dated, and notarized form may be mailed, faxed, or delivered to the lobby of INPRS using the address and contact information indicated on this form. The agency is closed on weekends and holidays, including all State-designated holidays.
7. Questions? Call customer service, toll-free, at (844) GO-INPRS, Monday through Friday.

FUND/PLAN/SYSTEM DESIGNATION

The **State Employee** named in this claim was a member of the following fund/plan/system. *(Select only one.)*

☐ Judges' Retirement System (JRS)	☐ Prosecuting Attorneys' Retirement Fund (PARF)	☐ Teachers' Retirement Fund (TRF) (*as a state employee*)
☐ Legislators' Retirement System (LRS)	☐ Public Employees' Retirement Fund (PERF)	

STATE EMPLOYEE INFORMATION

State employee name *(First, Middle initial, Last)*	Social Security number *(last 4 digits)**	Pension ID (PID) number
Address *(last address, number and street)*		Date of death (*mm/dd/yyyy*)
City	State	ZIP Code

CLAIMANT INFORMATION

Claimant name *(First, Middle initial, Last)*	Social Security number* - -	Date of application (*mm/dd/yyyy*)
Address *(number and street)*	Telephone number with area code	Other telephone number with area code

City	State	ZIP Code	E-mail address

ACCIDENT/INCIDENT INFORMATION

Date of accident/incident (*mm/dd/yyyy*)		Time of accident/incident (*hour: minutes and AM or PM*)	

Indicate the status of the following documentation:

☐ Attached ☐ Previously submitted	Detailed accident/incident report. (*Must be submitted on the employer's letterhead and have the notarized signature of an authorized official of the employer.*)
☐ Attached ☐ Previously submitted	Accident/incident investigation report. (*Must have the notarized signature of the investigating official or the investigating agency's records custodian.*)
☐ Attached ☐ Previously submitted	Death certificate. (*Must bear the seal of the Medical Examiner or the Department of Health.*)
☐ Completed	EMPLOYER AFFIDAVIT section of this form. (*Must be completed, signed, and dated when submitting this form to INPRS.*)

IMPORTANT: This claim cannot be processed until all of these documents are received by INPRS.

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State employee name *(First, Middle initial, Last)*	Social Security number *(last 4 digits)**	Pension ID (PID) number

EMPLOYER INFORMATION			
Employer name (*include department, division, and section*)			
Employer address *(number and street)*	City	State	ZIP Code
Immediate supervisor name			
Immediate supervisor address *(number and street)*	City	State	ZIP Code
Immediate supervisor e-mail address	Immediate supervisor telephone number with area code		

CLAIMANT(S) AFFIDAVIT

Select only one:

☐ I hereby certify that I am a dependent child of the deceased state employee named on this claim form. I also certify that I am listed as a dependent on the federal income tax return filed by this state employee in the year before the year in which the state employee died. All claimants who are dependent children who meet the definition of a dependent under IC 5-10-11-5(b) must sign and date this affidavit if they are 18 years of age or older.

☐ I hereby certify that I am the court-appointed guardian of the named dependent child/children of the deceased state employee named in this affidavit who are under 18 years of age.

☐ I hereby certify that I am the surviving spouse of the deceased state employee named in this claim form.

List ONLY eligible claimants. If the surviving spouse is the eligible claimant, there is no information that needs to be entered regarding dependent children or step-children on this form. Claimants who are the spouse or if the spouse is deceased a dependent child or step-child who is a dependent claimed on the federal income tax return filed by this state employee in the year before the year in which the state employee died must sign this affidavit. For claimants with a court-appointed guardian, the court-appointed. guardian must sign this affidavit. (*Attach additional pages with information, if needed. Be sure to include the state employee's name, Social Security number, and PID at the top of each additional page submitted with this form.)*

Beneficiary name (*First, Middle initial, Last*)	**Social Security number***	**Date of birth** (*mm/dd/yyyy*)	**Type of claimant** *(Select only one)*
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)
	- -		☐ Spouse ☐ Dependent child 18 or over ☐ Dependent child with guardian (guardian must sign affidavit)

CLAIM FOR STATE EMPLOYEE LINE OF DUTY DEATH BENEFIT FOR A SPOUSE, OR DEPENDENT CHILD AS BENEFICIARY

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State employee name *(First, Middle initial, Last)*	Social Security number *(last 4 digits)**	Pension ID (PID) number

CLAIMANT(S) AFFIDAVIT *(Continued)*

Each claimant named above attest that the following statements are true:

- I am the person who completed this application.
- In the case of a dependent child/children, there is no surviving spouse eligible for this benefit.
- There are no dependent child/children other than those listed above.
- I have carefully read the claim form and all of the information provided with this claim form, including all instructions and supplemental documents.
- All of the information I have provided and the questions I have answered are full, complete, and true, and that no material fact has been concealed or omitted.

Guardian name (*First, Middle initial, Last*)	Guardian e-mail address	Guardian telephone number with area code

Guardian address *(number and street)*	City	State	ZIP Code

Claimant or guardian signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*
Claimant signature	Date *(mm/dd/yyyy)*

SURVIVING CHILDREN

List surviving children if eligible. If the surviving spouse is the claimant, then no information needs to be entered in this section. (*Attach additional pages with information, if needed. Be sure to include the State Employee's name, Social Security number, and PID at the top of each page.)*

Surviving child name (*First, Middle initial, Last*)	**Social Security number***	**Date of birth** (*mm/dd/yyyy*)
	- -	
	- -	
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	- -	
	- -	
	- -	
	- -	
	- -	
	- -	

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State employee name *(First, Middle initial, Last)*	Social Security number *(last 4 digits)**	Pension ID (PID) number

EMPLOYER AFFIDAVIT

In order to qualify for the special death benefit authorized in IC 5-10-11-5, the decedent must have died in the line of duty as defined, for state employees, who are not public safety officers or employees of state educational institutions, in IC 5-10-11-3. Dies "in the line of duty" is defined in IC 5-10-11-2 as a "death that occurs as a direct result of personal injury or illness resulting from a state employee's performance of the duties of the employee's job."

In my capacity as head of the agency for which _____,
State Employee's Name *(First, Middle initial, Last)*

Social Security number* _____-_____-_____, worked on the date of the State Employee's death, _____, I hereby
Social Security number* Date of Death *(mm/dd/yyyy)*

certify that the member ☐ did or ☐ did not *(check one)* die in the line of duty as defined by IC 5-10-11-2 in accordance with the above stated law. In making this certification, I acknowledge that I am not making the final determination regarding whether or not

_____, died in the Line of Duty and I recognize that INPRS has
State Employee's Name *(First, Middle initial, Last)*

the authority to make the final determination in this regard. I understand that INPRS will make the determination based in whole or part on the information provided by me.

I am basing my opinion on the following facts and circumstances:

Authorized representative's signature	Authorized representative's title
Authorized representative's printed name	Date *(mm/dd/yyyy)*

NOTARY PUBLIC CERTIFICATION

State of _____

SS: SEAL

County of _____

Before me the undersigned, a Notary Public for _____ County, State of _____,
Officer's county of residence Officer's state of residence

personally appeared _____ and the claimant, being first duly sworn by me upon
Name of person

the claimant's oath, say that the facts alleged in the foregoing instrument are true.

Signed and sealed this _____ day of _____, 20_____. _____
Signature

My commission expires: _____ _____
Date *(mm/dd/yyyy)* Name of officer (*printed or typed*)

LINE OF DUTY DEATH GENERAL INFORMATION

Special Death Benefit Fund (SDBF)

Effective July 1, 2017, the State Employees' Death Benefit Fund, Public Safety Officers' Benefit Fund, and the lump sum distributions for the line of duty deaths from the Local Public Safety Pension Relief Fund were merged together to form the Special Death Benefit Fund. The lump sum distributions from the SDBF:

1. $100,000 for state employees
2. for public safety officers or other eligible officers (as defined by IC 5-10-10-4.5) who die in the line of duty:
   a. prior to July 1, 2020, $150,000
   b. on or after July 1, 2020, $225,000

State Employee Definition of "dies in the line of duty"

Death that occurs as a direct result of personal injury or illness resulting from a state employee's performance of the duties of the employee's job. IC 5-10-11-2.

Definition of "state employee"

An employee of a state agency, except a state educational institution. "State employee" does not include a public safety officer who receives benefits under IC 5-10-10.

Questions? Call customer service, toll-free, at (844) GO-INPRS, Monday through Friday.

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IMPORTANT

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2. Remove any instruction pages included with this form prior to returning the completed form to the Indiana Public Retirement System (INPRS) at the address shown above. Include an English translation of all foreign documents.
3. Type or print using black ink. Complete all information and place the State Employee's name, Social Security number and Pension ID number at the top of each page and on any additional pages of information being submitted.
4. Dependent child/children are defined by statute as dependents claimed on the federal income tax returned filed by the State Employee in the year before the year in which the State Employee died (IC 5-10-11-5(b)).
5. If you are filing this claim as guardian of a dependent child/children include documentation establishing your guardianship such as Letters of Guardianship or a court order.
6. This completed, signed, dated, and notarized form may be mailed, faxed, or delivered to the lobby of INPRS using the address and contact information indicated on this form. The agency is closed on weekends and holidays, including all State-designated holidays.
7. Questions? Call customer service, toll-free, at (844) GO-INPRS, Monday through Friday.

Entry field	Field description
FUND/PLAN/SYSTEM DESIGNATION	
Select only one	Select only one of the choices offered for the **State Employee.**
STATE EMPLOYEE INFORMATION	
Name	Enter the complete name of the State Employee *(First, Middle initial, Last)*.
Social Security number*	Enter the last 4-digits of the State Employee Social Security number.*
Pension ID (PID) number	Enter the Pension ID number of the State Employee.
Address, City, State, ZIP Code	Enter the State Employee last address *(number and street, City, State, ZIP Code)*.
Date of death	Enter the date of death for the deceased State Employee. Format = *mm/dd/yyyy*.
CLAIMANT INFORMATION	
Name	Enter the claimant complete name *(First, Middle initial, Last)*.
Social Security number*	Enter the claimant complete Social Security number.*
Date of application	Enter the date of the application. Format = *mm/dd/yyyy*.
Address, City, State, ZIP Code	Enter the claimant mailing address *(number and street, City, State, ZIP Code)*.
Telephone number/Other telephone number	Enter claimant telephone numbers including area codes.
E-mail address	Enter the claimant e-mail address, if applicable.
ACCIDENT/INCIDENT INFORMATION	
Date of accident/incident	Enter the date. Format = *mm/dd/yyyy*.
Time of accident/incident	Enter the time in HH:MM and indicate if AM or PM.
Detailed accident/incident report	Indicate if this is attached to this form or has been previously submitted. This report must be submitted on the employer letterhead and must have the notarized signature of an authorized official of the employer.
Accident/incident investigation report	Indicate if this is attached to this form or has been previously submitted. This report must have the notarized signature of the investigating official or the investigating agency records custodian.
Death certificate	Indicate if this is attached to this form or has been previously submitted. This must bear the seal of the Medical Examiner or the Department of Health.
EMPLOYER AFFIDAVIT section	Indicate that this section has been completed, signed, and dated and is included with the submission of this form to INPRS.
IMPORTANT: This claim cannot be processed until all of these documents are received by INPRS.	
EMPLOYER INFORMATION	
Employer name	Enter the full name of the employer, including department, division, and section.
Employer address, City, State, ZIP Code	Enter the employer mailing address *(number and street, City, State, ZIP Code)*.
Immediate supervisor name	Enter the deceased State Employee immediate supervisor name.
Immediate supervisor address, City, State, ZIP Code	Enter the deceased State Employee immediate supervisor mailing address *(number and street, City, State, ZIP Code)*.
Immediate supervisor e-mail address	Enter the deceased State Employee immediate supervisor e-mail address.
Immediate supervisor telephone number	Enter the deceased State Employee immediate supervisor telephone number with area code and extension, if applicable.
CLAIMANT(S) AFFIDAVIT	
Select only one	Select either the spouse, dependent child over 18 years of age or the court-appointed guardian of a dependent child.
List ONLY eligible claimants. If the surviving spouse is the eligible claimant, there is no information that needs to be entered regarding dependent children or step-children on this form. Claimants who are the spouse or if the spouse is deceased a dependent child or step-child who is a dependent claimed on the federal income tax return filed by this state employee in the year before the year in which the state employee died must sign this affidavit. For claimants with a court-appointed guardian, the court-appointed. guardian must sign this affidavit. (*Attach additional pages with information, if needed. Be sure to include the state employee name, Social Security number, and PID at the top of each additional page submitted with this form.)*	

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Entry field	Field description
Beneficiary name	Enter the beneficiary full name *(First, Middle Initial, Last name).*
Social Security number*	Enter the beneficiary complete Social Security number.*
Date of birth	Enter the beneficiary date of birth. Format = *mm/dd/yyyy*
Type of claimant	Select only one of the 3 options offered per claimant. If "Dependent child with guardian" is chosen the guardian must sign affidavit in the provided space.
Read all of the statements before continuing. The guardian attests to the list of statements included in this section of the form.	
Guardian name	This only needs to be completed if there is a court-appointed guardian for a dependent child. Enter the guardian complete name *(First, Middle initial, Last)*.
Guardian address, City, State, ZIP Code	Enter the guardian mailing address, if applicable *(number and street, City, State, ZIP Code)*.
Guardian e-mail address	Enter the guardian e-mail address, if applicable.
Guardian telephone number	Enter the guardian telephone number with area code, if applicable.
Claimant or guardian signature and date	The claimant or court-appointed guardian must sign and date the form. Format = *mm/dd/yyyy*.
Claimant signature and date	Space is provided for all named beneficiaries, if applicable. Each claimant named on the form must sign and date this form.
IMPORTANT: If not already submitted to INPRS, a copy of both the member and the claimant birth certificate, a baptismal or confirmation certificate, adoption papers, or a court decree are acceptable. If you are filing this claim as guardian of a child, include documentation establishing your guardianship such as a Letter of Guardianship or a court order. Include an English translation to any foreign document.	
SURVIVING CHILDREN	
List surviving children if eligible. If the surviving spouse is the claimant, then no information needs to be entered in this section. (*Attach additional pages with information, if needed. Be sure to include the State Employee name, Social Security number, and PID at the top of each page.)*.	
Surviving child name	Enter the surviving child name *(First, Middle Initial, Last name)*
Social Security number*	Enter the surviving child complete Social Security number.*
Date of birth	Enter the date of birth of the surviving child. Format = *mm/dd/yyyy*
EMPLOYER AFFIDAVIT	
The signatory to this affidavit attests to the statements shown in this section of the Line of Duty claim form. This section must be completed for the claim to be accepted and processed by INPRS.	
State Employee Name	Enter the State Employee full name *(First, Middle initial, Last)*.
Social Security number*	Enter the State Employee complete Social Security number.*
Date of death	Enter the date of death of the State Employee. Format = *mm/dd/yyyy*.
Check one	Check either "did" or "did not" die in the line of duty.
State Employee Name (second entry)	Enter the State Employee full name *(First, Middle initial, Last)*.
I am basing my opinion on the following facts and circumstances	Enter a brief explanation of your opinion regarding the designation of a line of duty death for consideration by INPRS in processing this claim.
Authorized representative signature	This form must be signed by the authorized representative.
Authorized representative title	Enter the authorized representative title
Authorized representative printed name	Enter the authorized representative printed name
Date	Enter the date the form was signed by the authorized representative. Format = *mm/dd/yyyy*
NOTARY PUBLIC CERTIFICATION	
This claim form must be notarized before it can be processed by INPRS. Take the form to a Notary Public with an active commission. You will be required to sign and date the form in the Notary presence. The notary must then complete the NOTARY PUBLIC CERTIFICATION section of the form and affix the Notary seal.	
LINE OF DUTY GENERAL INFORMATION	
This section should be reviewed carefully as it defines acceptable circumstances for filing a line of duty death claim with INPRS according to the fund/plan/system chosen in the FUND/PLAN/SYSTEM DESIGNATION section of this form. Questions? Call customer service, toll-free, at (844) GO-INPRS, Monday through Friday.	

HELPFUL INFORMATION			
	INPRS	**INTERNAL REVENUE SERVICE**	**INDIANA DEPARTMENT OF REVENUE**
Telephone numbers	(844) GO-INPRS (Toll-free)	(800) 829-1040 (Toll-free)	(317) 233-2240 Indianapolis local
	(866) 591-9441 Fax (Toll-free)	(800) 829-4477 TeleTax	(317) 232-8729 Tax questions
		(800) 829-4059 TDD (hearing impaired)	(317) 232-4952 TDD (hearing impaired)
			(317) 233-2329 Fax
Web site	www.inprs.in.gov	www.irs.gov	www.in.gov/dor