

Death Benefit Payment Form

NAME OF DECEASED EMPLOYEE _____ **SOC SEC NUMBER** _____ - _____ - _____

DEPT-DIV-LOC _____ **INDEX CODE** _____

CURRENT BIWEEKLY PAY \$ _____ **DATE OF DEATH** _____

DPR'S SIGNATURE _____ **TELEPHONE NUMBER ()** _____

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 PLEASE ATTACH A **CERTIFIED COPY OF THE DEATH CERTIFICATE** AND A COPY OF THE MOST RECENT COUNTY DEATH BENEFIT BENEFICIARY DESIGNATION FORM OR FRS BENEFICIARY DESIGNATION FORM AND IRS FORM W-9.
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Please issue a check per Resolution R-1278-70, payable to: (Please fill out "A" or "B" as applicable)

A. THE BENEFICIARY(IES)

Name	Social Security No.	Date of Birth

NOTE: PAYMENT WILL NOT BE MADE WITHOUT THE PROPER "SSN" OR "TIN"

B. THE ESTATE - Taxpayer ID No. (TIN) of Estate:

C.

Street Address of Beneficiary	City, State Zip Code

If additional space is needed, please attach to form.

Amount to be Paid: \$ _____ (Less than 10 years - one pay period's regular salary plus \$2,000.00)
 \$ _____ (Less than 20 years- two pay period's regular salary plus \$4,000.00)
 \$ _____ (20 years or more - two pay period's regular salary plus \$6,000.00)

D. Deduction for Dependent Medical Coverage

_____ **Dependent Medical Provider** _____ **Deduction Amount**
 _____ **Dependent Dental Provider** _____ **Deduction Amount**
 _____ **Dependent Vision Provider** _____ **Deduction Amount**

Do you wish to have dependent coverage premiums deducted from the death benefit check (s)?

Yes _____ No _____

_____ **Beneficiary's Signature** _____ **Date** _____ **Beneficiary's Signature** _____ **Date** _____

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EMPLOYEE BENEFITS OFFICE USE ONLY

Beneficiary verified by: _____

Date: _____