Death Benefit Payment Form

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

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

DPR SIGNATURE _____ **TELEPHONE NUMBER (___)** _____

INFORMS DEPT ID _____ **INFORMS BU***_____

INFORMS FUND _____ **INFORMS PROJECT***_____

INFORMS GRANT _____ **INFORMS ACTIVITY***_____ *If applicable

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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: _____

Revised 08/16/2023