



# THE COMMONWEALTH OF MASSACHUSETTS State Board of Retirement

## APPLICATION FOR ACCIDENTAL DEATH BENEFITS

### APPLICATION PROCESS CHECKLIST

When filing your **Application for Accidental Death Benefits**, please include the following documents:

- Narrative from the treating physician on the cause of death.
- Copy of death certificate.
- Copy of marriage certificate.
- Copy of surviving spouse's birth certificate.

### INSTRUCTIONS

A member's eligible survivor may be entitled to an accidental death benefit if the member's death is the natural and proximate **result** of a personal injury sustained or hazard undergone while in the performance of his/her duties and without serious and willful misconduct on the member's part. Special provisions are applicable to firefighters, police officers, corrections officers, and public prosecutors. G.L. c.32, §100.

Alternatively, if a job-related accident or exposure to a hazard **causes** the death of a member-in-service, the member's accumulated deductions and related interest will be paid to his/her beneficiaries of record in one sum. The beneficiaries who receive the accumulated deductions are not necessarily the same as the beneficiaries eligible to receive the pension portion of the accidental death benefit. G.L. c.32, §9.

An additional pension benefit is available to an eligible beneficiary if the death of a member-in-service is caused by a job-related accident. The eligible beneficiary of the member's pension benefit will receive a yearly pension equal to either 72% of the annual rate of regular compensation, which the member had been earning on the date of the injury or 72% of the average annual rate of regular compensation for the 12-month period for which the member last received regular compensation, whichever is greater.

Please complete and return the **Application for Accidental Death Benefits** (pages 2 and 3). **Important:** The applicant's signature on this application must be witnessed. The witness must complete and sign the **Witness Statement** found on page 4.

Please return completed form to:

State Retirement Board, One Winter Street, 8th Floor, Boston, MA 02108

For more information call (617) 367-7770 or 1-800-392-6014 (Mass. only) - fax # (617) 723-1438

Please notify the Retirement Board of any change of address.



### IMPORTANT

A copy of the **narrative from the treating physician on the cause of death**, a copy of **death certificate**, a copy of **marriage certificate**, and a copy of the **surviving spouse's birth certificate** must be enclosed with this application.

To the State Board of Retirement:

I, \_\_\_\_\_ whose place of residence is \_\_\_\_\_  
(Name of Applicant)

\_\_\_\_\_  
(Street and Number, City or Town, State, and Zip Code)

hereby certify in connection with this Application for an Accidental Death Benefit under the provisions of Section 9 (nine) or section 100 (one hundred) of Chapter 32 of the General Laws as follows:

**1** That \_\_\_\_\_ formerly employed in \_\_\_\_\_  
(Full Name of Deceased/Social Security Number)  
the service of the Commonwealth in the \_\_\_\_\_ died on \_\_\_\_\_  
(Name of Department, Division, or Institution) (Month, Day, Year)  
in the City or Town of \_\_\_\_\_  
(Name of City or Town)

If Deceased member was in active service, please complete question #2;  
if Deceased member was retired, please complete question #3:

**2** That, in my opinion, death was caused or resulted from bodily injuries sustained or a hazard undergone on \_\_\_\_\_, while in the performance and within the scope of duty, the nature of which was as follows (*give a complete description; if statement requires more space, please continue on a separate sheet of paper and include with this application*):  
(Month, Day, Year)

**3** That, in my opinion, death was the natural and proximate result of the injury or hazard on account of which member was retired under Accidental Disability, the nature of which was as follows (*give a complete description; if statement requires more space, please continue on a separate sheet of paper and include with this application*):

4 That the legal marital status of Deceased at time of death was:  Single  Married  Widowed  Divorced

If Married, Widowed, or Divorced, spouse of: \_\_\_\_\_  
(Full Name of Spouse/Former Spouse)

5 That the following children **Under 18** (eighteen) years of age, or age 18 to age 22 if fulltime student (letter from Registrar of school attesting that child is fulltime student), survive the Deceased:

(If no such child survives, the word **NONE** must be written in the space below.)

\_\_\_\_\_  
(Full Name) (Address) (Month, Day and Year of Birth)\*

\_\_\_\_\_  
(Full Name) (Address) (Month, Day and Year of Birth)\*

\_\_\_\_\_  
(Full Name) (Address) (Month, Day and Year of Birth)\*

\*Copy of Birth Certificate required

6 That the following physically or mentally incapacitated dependent children survive the Deceased:

(If no such child survives, the word **NONE** must be written in the space below.)

\_\_\_\_\_  
(Full Name) (Address) (Month, Day and Year of Birth)\*

\_\_\_\_\_  
(Full Name) (Address) (Month, Day and Year of Birth)\*

\_\_\_\_\_  
(Full Name) (Address) (Month, Day and Year of Birth)\*

\*Copy of Birth Certificate required

7 That the parents of the Deceased are:

\_\_\_\_\_  
(Father's Full Name) (Mother's Full Maiden Name)

\_\_\_\_\_  
(Home Address, if living) (Home Address, if living)

\_\_\_\_\_  
(If possible, please give Date and Place of Father's Death) (If possible, please give Date and Place of Mother's Death)

8 That I, the surviving \_\_\_\_\_, hereby apply for the accidental death benefit under aforesaid law.  
(Relationship to Deceased)

**If applicant is spouse of Deceased, please complete question A; if applicant is parent of Deceased, please complete question B:**

I further certify that: (A) At the time of injury and death were you LIVING TOGETHER?  Yes  No

(B) At the time of injury and death I was PRINCIPALLY DEPENDENT upon said

\_\_\_\_\_ for support.  
(Son / Daughter)

9 THAT THE ABOVE STATEMENTS ARE TRUE AND ARE MADE UNDER THE PENALTIES OF PERJURY.

**IMPORTANT: SIGNATURE MUST BE MADE IN INK**

_____ (Signature of Person Making Application)	_____ (Date Signed)	_____ (Social Security Number of Applicant)
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**SIGNATURE OF WITNESS IS REQUIRED**

THE APPLICANT'S SIGNATURE ON THIS APPLICATION FOR ACCIDENTAL DEATH BENEFITS MUST BE WITNESSED.

**Witness must complete the Witness Statement which follows on page 4 of this application.**

## WITNESS STATEMENT

I, the undersigned, certify that I have known the applicant for \_\_\_\_\_ years, and that he/she signed the foregoing instrument in my presence, and that I certify UNDER THE PENALTIES OF PERJURY the answer to the following questions:

**WITNESS:** If applicant is spouse of the Deceased, please complete question 1; if applicant is parent of the Deceased, please complete question 2:

1.] Were the husband and wife **LIVING TOGETHER** at the time of (a) injury, and (b) death?  Yes  No

2.] At the time of death, was the parent principally dependent upon the Deceased for support?  Yes  No

\_\_\_\_\_  
(Signature of Witness—First, Middle, Last)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Witness' Mailing/Home Address—Street and Number, City or Town, State, and Zip Code)

**PLEASE NOTE, SIGNATURE IS REQUIRED. THE MAILING (HOME) ADDRESS OF THE WITNESS MUST BE GIVEN.  
SIGNATURE MUST BE WRITTEN IN INK.**