MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

CLAIM FOR COMPENSATION FOR LINE OF DUTY COMPENSATION BENEFITS

P.O. Box 58
Jefferson City, MO 65102-0058
573-526-4941
labor.mo.gov/DWC

(Use this form when the worker's death occurred on or after August 28, 2017, and before August 28, 2018.)

Instructions:

1. Type or print clearly in ink.
2. Claim must be filed by the survivors of the deceased.
3. Last page of this form must be signed by claimant and notarized.
4. If question is not applicable, please answer with N/A.
5. Claim may be filed in person at any of the Division's adjudication offices or by mail at the address indicated above.
6. Claim must be filed within one year of the date of death of an air ambulance pilot, air ambulance registered professional nurse, emergency medical technician, firefighter, law enforcement officer or volunteer firefighter killed in the line of duty.

FOR DIVISION USE ONLY

Case Number: _____

Date Received: _____

A. Pursuant to the provisions of the Line of Duty Compensation Act, §287.243, RSMo, as amended, application is hereby made for payment of benefits as follows:

1. Decedent's Name		2. Decedent's Social Security Number
3. Address of Decedent's Missouri residence at time of death		3a. If no Missouri Address, please provide the address of decedent's residence at time of death
4. Date of Death	5. Date of Injury resulting in death	6. Employer's Name and Address
7. Place of Injury causing death		
8. Rank and Title of Position or designation of the position in which Decedent was serving at time of death, or at time of injury resulting in death		
9. Decedent's Marital Status at time of death		10. (If applicable) Name, Address, Phone Number and Social Security Number (last four digits) of Decedent's surviving spouse
11. Did Decedent have children? ☐ Yes ☐ No		
12. Please attach copies of the following documents (if available) that provide a full, factual account of the circumstances resulting in or the course of events causing the Decedent's death: A. Report of Casualty or Accident filed with the employer; B. Certificate of Death; C. Police Report; D. Autopsy Report; E. Medical Records; F. Toxicology Report.		
13. Please attach a copy of a full, factual account that explains how Decedent died in the active performance of his or her duties in his or her respective profession. If Decedent's employer will provide an official statement of the circumstances surrounding Decedent's fatal injury, please include a copy. Otherwise, please provide a written factual account of the circumstances surrounding Decedent's fatal injury insofar as they are known to Claimant(s) at the time of the filing of this Claim for Compensation for Line of Duty Compensation Benefits.		

B. Claimant Information – A claim shall be filed by survivors of deceased. Please specify below if a claim is being filed by the surviving spouse or a "child". Section 287.243.2(3) defines "child" as any natural, illegitimate, adopted or posthumous child or stepchild of the deceased who is 18 years of age or younger; or over 18 years of age and a student as defined in 5 U.S.C. Section 8101; or over 18 years of age and incapable of self-support because of physical or mental disability. If you are not a surviving spouse or "child" as defined by Section 287.243.2(3), please proceed to section C of this form.

1. Claimant's Name	2. Claimant's Address
3. Phone Number Home: Work:	
4. Claimant's Name (if child, please list child's name) (if more than one child, please attach an additional sheets with the child's name, address and parent or guardian information)	5. Claimant's Address (if child, please indicate address of parent or natural guardian)
6. Phone Number Home: Work:	

7. Please attach the following documents:
   A. Certified Copy of Marriage Certificate (for surviving spouse)
   B. Certified Copy of the Birth Certificate for each child claiming benefits or Court Order determining the child's parentage
   C. If benefits are being claimed on behalf of a child who is under 18 by a person other than the child's surviving natural parent, attach a Certified Copy of the Court Order appointing a Guardian for the child and a Certified Copy of the Court Order appointing the claimant as the Conservator of Estate of the child.
   D. If benefits are being claimed on behalf of a child who is over 18 and disabled, attach a Certified Copy of the Court Order appointing a guardian for the disabled child and a Certified Copy of the Court Order appointing the claimant as the Conservator of the Estate of the disabled child.
   E. In the case of an illegitimate child, a copy of the court order determining paternity/maternity.

C. If you are an individual under executed designation of beneficiary form, or an individual designated on the most recently executed life insurance policy, or a surviving parent or parents, or an individual who would qualify as a "child" under Section 287.243.2(3) but for age, please complete the information below and attach a copy of the designation of beneficiary form or Decedent's or child's birth certificate (to show parentage).

1. Claimant's Name	2. Claimant's Address
3. Phone Number Home: Work:	4. Relationship to Decedent

D. If an estate has been opened, please complete the following information:

1. Relationship to Decedent
2. A Petition for Issuance of Letters of Administration was filed In the Circuit Court of _____ County, Probate Division, Estate Number: _____
3. A full probate administration was not required based upon the following: A. Refusal of Letters to surviving spouse or unmarried minor, minor, or dependent children ordered by the Circuit Court; a. County and State: b. Estate Number: B. Determination of Heirship in an intestate case. a. County and State: b. Estate Number:

4. If available and/or applicable, please attach the following documents:
   A. Certified copy of the Order granting Refusal of Letters to surviving spouse or unmarried minor, minor, or dependent children entered by the Circuit Court;
   B. Certified copy of the Circuit Court Order on the Determination of Heirship;
   C. Certified copy of the Circuit Court Order on small estate procedures;
   D. Certified copy of the Circuit Court Order on Termination of Administration and approval of the final settlement of the estate;
   E. Court's Decree of Final Distribution

E. Additional Information

1. Please attach copies of any other documents that may be relevant or useful in consideration of this claim.	
2. Please check the appropriate box below: I ☐ am ☐ am not currently represented by an attorney. I agree to notify the Division in writing if and when I hire an attorney to represent me in this case.	3. Name and Address of the Attorney representing the estate
4. Name and address of the attorney representing the claimant on this Claim for Compensation for Line of Duty Benefits claim:	

STATE OF_____)
)
COUNTY OF_____)

_____ on oath, states that the information in the foregoing application was completed by, or at the direction of, the undersigned and that matters stated therein are true and correct.

_____
Claimant's Signature

Subscribed and sworn to before me this

_____ day of_____, 2_____.

Notary Seal

_____
Notary Public

Please visit the Division's website at labor.mo.gov/DWC/Injured_Workers/survivor_benefits for additional information relating to Survivor's Benefits or for a copy of the brochure. A copy of Senate Bill 66, which includes the legislative changes made to the Line of Duty Compensation Program in 2017, can be found online at senate.mo.gov/17info/BTS_Web/Bill.aspx?SessionType=R&BillID=57095462.