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

State Form 55761 (1-15)

INDIANA PUBLIC RETIREMENT SYSTEM
STATE EMPLOYEE DEATH BENEFIT FUND
1 North Capitol Avenue, Suite 001
Indianapolis, IN 46204-2014
Telephone: (888) 526-1687 (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. 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.
2. Type or print using black ink. Complete all information and place the State Employee's name, last four digits of the Social Security number and Pension ID number at the top of each page as requested.
3. Dependent child/children are defined by statute as dependents claimed on the federal income tax return filed by this state employee in the year before the year in which the state employee died (IC 5-10-11-5(b)).
4. 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.
5. Include an English translation of all foreign documents.
6. This completed form may be delivered to the lobby of INPRS at the address indicated on the form. Lobby hours are 8 a.m. to 5 p.m. on weekdays. The agency is closed on weekends and holidays, including all State-designated holidays.
7. Questions? Call customer service, toll-free, at (888) 526-1687, Monday – Friday, 8 a.m.- 8 p.m. EST.

STATE EMPLOYEE INFORMATION

Name	Social Security number *(last 4 digits)**	Pension ID (PID) number
Address		Date of death (*mm/dd/yyyy*)

CLAIMANT INFORMATION

Name		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.*)

Name	Social Security number *(last 4 digits)**	Pension ID (PID) number

EMPLOYER INFORMATION

Employer's name (*include department, division, and section*)			
Employer's address *(number and street)*	City	State	ZIP Code
Immediate supervisor's name			
Immediate supervisor's address *(number and street)*	City	State	ZIP Code
Immediate supervisor's e-mail address	Immediate supervisor's 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 in 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 all eligible claimants. Claimants who are the spouse or if the spouse is deceased a dependent child age 18 or older 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.)*

Beneficiary's 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)
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			☐ Spouse ☐ dependent child 18 or over ☐ dependent child with guardian (guardian must sign affidavit)

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 other 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's name	Guardian's e-mail address	Guardian's telephone number with area code	
Guardian's address	City	State	ZIP Code

Name	Social Security number *(last 4 digits)**	Pension ID (PID) number
Claimant's or guardian's signature		Date *(mm/dd/yyyy)*

CLAIMANT(S) AFFIDAVIT *(Continued)*	
Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*
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Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*
Claimant's signature	Date *(mm/dd/yyyy)*

NOTARY PUBLIC CERTIFICATION

State of _____

SS:

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 he/she, being first duly sworn by me upon his/her oath,
Name of person

say that the facts alleged in the foregoing instrument are true. SEAL

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

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

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IMPORTANT

1. 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 on the form.
2. 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 as requested.
3. If you are filing this claim as guardian of a dependent child/children include documentation establishing your guardianship such as a court order.
4. A child or stepchild is defined by statute (IC 5-10-11-5(b)) as a dependent of the state employee if the child or stepchild was claimed as a dependent on the federal income tax return filed by the state employee in the year before the year in which the state employee died.
5. Include an English translation of all foreign documents.
6. This completed form may be delivered to the lobby of INPRS at the address indicated on the form. Lobby hours are 8 a.m. to 5 p.m. on weekdays. The agency is closed on weekends and holidays, including all State-designated holidays.
7. Questions? Call customer service, toll-free, at (888) 526-1687, Monday – Friday, 8 a.m.- 8 p.m. EST.

Entry field	Field description
STATE EMPLOYEE INFORMATION	
Name	Enter the complete name of the State Employee
Social Security number	Enter the last 4-digits of the State Employee's Social Security number.
Pension ID (PID) number	Enter the Pension ID number of the State Employee.
Address	Enter the State Employee's last address.
Date of death	Enter the date of death for the deceased State Employee; format = mm/dd/yyyy.
CLAIMANT INFORMATION	
Name	Enter the claimant's complete name.
Social Security number	Enter the claimant's nine-digit Social Security number.
Date of application	Enter the date of the application; format = mm/dd/yyyy.
Address	Enter the claimant's street address and/or mailing address.
Telephone number/Other telephone number	Enter claimant's telephone numbers including area codes.
E-mail address	Enter the claimant's 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's 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's 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.
IMPORTANT: This claim cannot be processed until all of these documents are received by INPRS.	
EMPLOYER INFORMATION	
Employer's name	Enter the full name of the employer, including department, division, and section.
Employer's address	Enter the employer's street or mailing address.
Immediate supervisor's name	Enter the deceased State Employee's immediate supervisor's name.
Immediate supervisor's address	Enter the deceased State Employee's immediate supervisor's street or mailing address.
Immediate supervisor's e-mail address	Enter the deceased State Employee's immediate supervisor's e-mail address.
Immediate supervisor's telephone number	Enter the deceased State Employee's immediate supervisor's telephone number with area code and extension, if applicable.

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AFFIDAVIT BY THE SPOUSE, A DEPENDENT CHILD OR THE COURT-APPOINTED GUARDIAN OF A DEPENDENT CHILD	
Select only one	Select either the spouse, dependent child over 18 years of age or the court-appointed guardian of a dependent child.
Name of claimant or court-appointed guardian	Enter the full name of the claimant or court-appointed guardian.
Guardian's name	This only needs to be completed if there is a court-appointed guardian for a dependent child. Enter the guardian's complete name.
Guardian's address	Enter the guardian's street or mailing address, if applicable.
Guardian's e-mail address	Enter the guardian's e-mail address, if applicable.
Guardian's telephone number	Enter the guardian's telephone number with area code, if applicable.
Claimant's or guardian's signature and date	The claimant or court-appointed guardian must sign and date the form; format = mm/dd/yyyy. The signature must be notarized. The Notary must affix their seal.
IMPORTANT: If not already submitted to INPRS, a copy of both the member's and the claimant's 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.	

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's presence. The notary must then complete the NOTARY PUBLIC CERTIFICATION section of the form and affix the Notary's seal.

HELPFUL INFORMATION			
	INPRS	**INTERNAL REVENUE SERVICE**	**INDIANA DEPARTMENT OF REVENUE**
Telephone numbers	(888) 526-1687 (Toll-free)	(800) 829-1040 (Toll-free)	(317) 233-4018 Indianapolis local
	(866) 591-9441 Fax (Toll-free)	(800) 829-4477 TeleTax	(317) 232-2240 Tax questions
		(800) 829-4059 TDD (hearing impaired)	(317) 233-4952 TDD (hearing impaired)
			(317) 233-2329 Fax
Web site	www.inprs.in.gov	www.irs.gov	www.in.gov/dor