FPPA

Application Packet Cover Sheet

Fire & Police Pension Association of Colorado
FPPAco.org • 5290 DTC Parkway, Suite 100 • Greenwood Village, Colorado 80111-2721
(303) 770-3772 in the Denver Metro area • (800) 332-3772 toll free nationwide • (303) 771-7622 fax

For **Spouse or Children of a Member**

Who Has **Died in Active Service**

This Packet Applies To:
Spouse or children of a member who has died while in active service.

Please Remember:
- have the employer complete Part D
- submit all required documentation including the death certificate

Questions? Contact an FPPA Death & Disability Benefit Coordinator at the phone numbers listed above.

Send all completed forms to:
FPPA Death & Disability Benefit Coordinator at the address listed above.

Please make copies for your files of the forms you fill out prior to submitting them to FPPA.

Forms & Publications

In this application packet you will find the following forms and information needed to process your application.
Check the box to the LEFT as you complete each of the forms.

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Instructions Memo

This memorandum, together with the *FPPA Application for Survivor Benefits*, will explain the steps required to apply for survivor benefits. If you are the surviving spouse or dependent children of a deceased member, you may be covered for survivor benefits. As the applicant for survivor benefits, it is your responsibility to ensure that the application is completed properly and returned to FPPA. If eligible survivors have executed a power of attorney appointing you to act on their behalf, please attach a copy of the power of attorney to this application.

The application consists of 6 pages. You are responsible for submitting the required documentation and completing the entire application, except for Part D that is to be completed by the deceased member's employer.

Upon receipt of the application, FPPA staff will review it. If any information is missing you will be contacted. Once FPPA has received the complete application, we will schedule your case for the next available Death & Disability Review Committee (DDRC) meeting.

The DDRC will make a determination regarding survivor benefits, or your application may be referred for further review. You will receive written notification of the decision regarding your application. If you disagree with any aspect of the final outcome, there is a process to request an evidentiary hearing.

We realize this may not be an easy process to go through, so please feel free to call if you have questions or concerns at 303-770-3772 or 1-800-332-3772.

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APPLICATION FOR SURVIVOR BENEFITS

Dear Applicant,

This packet is your complete application for FPPA survivor benefits. FPPA provides survivor benefits to a deceased member's spouse and/or dependent children. FPPA survivor benefits including eligibility, benefit levels, and factors affecting benefits, are explained in the *FPPA Member Handbook* and in Part 8, Article 31, Title 31 of the *Colorado Revised Statutes,* as amended. These documents may be obtained from FPPA's office or web site (www.FPPAco.org). You are urged to consult these sources for more detailed information. Please feel free to contact FPPA's Benefits Department if you have questions.

Instructions:

As the applicant for survivor benefits, it is your responsibility to ensure that this packet is completed properly and returned to FPPA. If eligible survivors have executed a power of attorney appointing you to act on their behalf, please attach a certified copy of the power of attorney to this application.

If eligible survivors reside in separate households, a separate application must be filled for each household. An example of these circumstances would be if the deceased member's spouse lives in one household, and his/her children live in a second household. The guardian of the children in the second household must file an application on their behalf.

Each part of this application carries its own instructions. Please read them carefully. As the applicant, you are entirely responsible for completing Part A, Part B and Part C. Part D must be completed by the deceased member's employer. When completed, photocopy this application for your files and return the original, along with supporting documentation, to FPPA.

As soon as your application is received, FPPA will process it as quickly as possible. Applications for survivor benefits must be approved by FPPA. Meanwhile, if you have questions, please contact FPPA's Benefits Department at the address or phone number listed above.

IMPORTANT NOTE: If at any time you are not eligible for benefits and FPPA has inadvertently made an overpayment, you will be required to return the overpaid amount to FPPA.

Part A - Deceased Member Information

_____ _____ _____
Last Name First Initial

_____ _____
Mailing Address *(at the time of death)* Apt #

_____ _____ _____
City State Zip

_____ - _____ - _____ _____ / _____ / _____ _____ / _____ / _____
Social Security Number Date of Birth *(mo/day/yr)* Date of Death *(mo/day/yr)*

Part B - Applicant Information

(the recipient of the survivor benefits)

_____ _____ _____
Last Name First Initial

_____ - _____ - _____ _____ / _____ / _____ _____
Social Security Number Date of Birth *(mo/day/yr)* Email Address

_____ (_____) _____ - _____
Mailing Address *(street, city, zip)* Phone Number

Relationship of the applicant to the member:
- ☐ spouse
- ☐ guardian of the member's dependent child(ren)
- ☐ dependent child(ren)

Dependents:

► Please list below **ALL the deceased member's unmarried dependent children under age 23** (including natural, adopted and step children).

Dependent Child(ren)'s Name	Social Security Number	Birth Date *(Month, Day, Year)*	Was the member's household this child's permanent residence at the time of the member's death? *Yes*	*No*
_____	____/____/____	____/____/____	☐	☐
_____	____/____/____	____/____/____	☐	☐
_____	____/____/____	____/____/____	☐	☐

► Please list below any of your **children of any age you believe to be so mentally or physically incapacitated that he or she cannot provide for him or herself**.

Dependent Child(ren)'s Name	Social Security Number	Birth Date *(Month, Day, Year)*	Was the member's household this child's permanent residence at the time of the member's death? *Yes*	*No*
_____	____/____/____	____/____/____	☐	☐
_____	____/____/____	____/____/____	☐	☐
_____	____/____/____	____/____/____	☐	☐

Other Benefit:

Are you eligible to receive a survivor benefit from a local Colorado defined benefit pension plan in which the deceased participated? ☐ Yes ☐ No

Group Insurance:

For your convenience, FPPA may deduct group insurance payments. Please indicate any deductions below:

Name of Carrier	Type of Coverage**	Effective Date for Deduction	Amount
_____	_____	____/____/____	$_____.____
_____	_____	____/____/____	$_____.____

*** Single, two-party, family, Medicare*

_____ _____ _____/_____/_____
Print Applicant's Full Legal Name Applicant's Signature Date

1) State the cause of death. _____

_____

2) Do you claim that the member's death was the result of an injury received while performing the official duties of the fire/police department or an occupational disease arising out of or in the course of employment with the department? ☐ Yes ☐ No

3) If yes, please set forth the basis for your claim, including, if applicable, the date(s), time(s) and place(s) of the incident which led to the member's death.

_____

_____

_____

	Yes	*No*	
4) Was a Workers' Compensation claim filed in relation to the condition for which survivor benefits are requested?	☐	☐	
5) If yes, did Workers' Compensation accept liability for the cause of death?	☐	☐	*or* ☐ *Pending*

6) What is the Workers' Compensation Claim Number? _____

Important:

It is very important that all relevant documentation is included and attached to this application in order to support the on-duty status of the survivor benefits claim.

7) If you are claiming on-duty status, please check the supporting documentation included.

☐ Evidence that the death resulted from an injury or occupational disease that was compensable under the Workers' Compensation Act of Colorado as having occurred in the course of the member's employment, (See C.R.S. 8-40-201).

☐ Employer records as of the date of the injury which support the proposition that the death resulted from an injury received while performing official duties or an occupational disease arising out of and in the course of the member's employment.

☐ Other records or documents that support the proposition that the death resulted from an injury received while performing official duties or an occupational disease arising out of and in the course of the member's employment. Please list documents below.

_____

_____

_____

Please Note:

The information used to make this determination will include the information submitted with this application. Any information submitted should be concurrent with the date of death. FPPA will not be responsible for researching outside sources to obtain such information.

Signature of Applicant _____ Date_____

Part C - Supporting Documents

Please attach legible photocopies of all supporting documents listed below which apply to you. Check those documents attached.

- ☐ Member's death certificate
- ☐ Birth certificate of surviving spouse
- ☐ If survivor is female, a copy of a current marriage certificate or driver's license to verify name change.
- ☐ The birth certificates of deceased member's unmarried children under age 23, including natural children, adopted children, and stepchildren.
- ☐ A physician's statement certifying that a child has been conceived but not yet born. (**Note:** After birth, send FPPA a copy of the child's birth certificate.)
- ☐ A physician's statement certifying that a child is so physically or mentally incapacitated that he/she cannot provide for him/herself. (And, if such child is over the age of 23, the birth certificate of the child.)
- ☐ If the member participated in a local money purchase pension plan, a copy of an account balance statement as of the last day on payroll. If last day on payroll is a future date, attach a current account balance statement, with final statement submitted after last day on payroll. Also include a copy of the statement(s) showing the date(s) and amount(s) of any distribution(s).
- ☐ Copy of any Domestic Relations Order (DRO).
- ☐ If applicable, copy of a power of attorney.

► To The Employer:

Survivors of the deceased member identified in Part A of this application are applying for survivor benefits. **Please complete this Part D and return this application to the applicant or FPPA.** Your cooperation in this matter is appreciated.

_____ _____
Department *(Police, Fire or Fire Protection District)* City

_____ (_____) _____ - _____
Mailing Address *(Street, City and Zip)* Phone Number

_____ _____ / _____ /_____
Member's Name Member's Social Security Number

Member's Monthly Base Salary* $ _____.____

**See the FPPA Rule regarding definition of base salary for your plan on the FPPA website at www.FPPAco.org.*

Date of Hire ____ / ____ / ____ Last Day on Job ____ / ____ / ____ Last Day on Payroll _____ / _____ / _____

■ What coverage did the member have for normal retirement? (Check the plan that applies.)

☐ Statewide Defined Benefit Plan ☐ Statewide Hybrid Plan** ☐ local defined benefit plan*
☐ Statewide Money Purchase Plan** ☐ Colorado Springs New Hire Plan ☐ local money purchase plan**

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* If you checked the box for **local defined benefit plan** for this applicant, what are the age and service requirements for normal retirement under that plan?

Years of service requirement _____ Age requirement (if none, please use N/A) _____

- If the applicant met these requirements, please state the monthly survivor benefit amount payable to the: surviving spouse $ _____ dependent child(ren) $ _____
- How long will the above benefit(s) be payable? _____
- If your department affiliated with FPPA for pension purposes did the member take a distribution from a money purchase plan prior to affiliation? ☐ Yes ☐ No

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** If you checked the box for **money purchase plan** for this applicant, is he/she considered 100% vested upon approval of a long-term disability benefit? ☐ Yes ☐ No

If **No**, what is the member's vested percentage in each account?

Employer _____ % Employee _____%

Has the member taken a distribution from his/her **money purchase plan**? ☐ Yes ☐ No

If **YES**, please provide a copy of the statement showing all distributions.

If **YES**, was any part of the distribution made pursuant to a domestic relations order (DRO)? ☐ Yes ☐ No

■ Was the member on a leave of absence at the time of his/her death? ☐ Yes ☐ No

If **YES** was the leave of absence: ☐ Authorized ☐ Unauthorized

■ If the member was hired after January 1, 1997 please answer the following:

Who is paying the Death & Disability Contribution: Employee _____% ☐ Pre-tax ☐ Post-tax
Employer _____%

- Who is the Workers' Compensation Carrier? _____

_____ (_____) _____ - _____
Workers' Compensation Carrier Mailing Address *(Street, City and Zip)* Phone Number

- Date of Member's Death _____/_____/_____

- Cause of Member's Death _____

The Criteria
In making its decision whether a death was the result of an injury received while performing official duties or an occupational disease arising in the course of the member's employment, the Board will consider the following standards:

An "injury received while performing official duties" means an injury occurring:
1) during a scheduled shift of the member; or
2) while the member is otherwise performing official duties for the employer; or
3) while the member is performing official duties in the employ of a third party and the employment is authorized by the member's employer.

A member's official duties are those set forth in the written job description for the member's position.

An "occupational disease" will be determined to have resulted directly from the employment of the member, or the conditions under which work was performed, if it follows as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment as a proximate cause and does not come from a hazard to which the member would have been equally exposed outside of the member's employment.

- Was the member's death the result of an injury received while performing official duties or an occupational disease arising out of and in the course of the member's employment? ☐ Yes ☐ No

If you answered **Yes** to the preceding question, what supporting documentation is included with this application?

☐ Evidence that the death resulted from an injury or occupational disease that was compensable under the Workers' Compensation Act of Colorado as having occurred in the course of the member's employment, (See C.R.S. 8-40-201).

☐ Employer records as of the date of the injury which support the proposition that the death resulted from an injury received while performing official duties or an occupational disease arising out of and in the course of the member's employment.

☐ Other records or documents that support the proposition that the death resulted from an injury received while performing official duties or an occupational disease arising out of and in the course of the member's employment. Please list documents below.

_____

_____

_____

_____ _____
Name of Police Chief, Fire Chief or Personnel Director *(please print)* Title

_____ _____
Signature of Police Chief, Fire Chief or Personnel Director Date

_____ _____
Address Phone Number