

CLAIM FOR LINE OF DUTY ACT (LODA) BENEFITS



VIRGINIA LINE OF DUTY ACT (LODA)
 P.O. Box 2500 ♦ Richmond, Virginia 23218-2500
 Toll-free 1-888-VARETIR (827-3847)
 Fax 1-804-786-9718
 www.valoda.org

1. Type of Benefit (Choose one) <input type="checkbox"/> Death <input type="checkbox"/> Disability
2. Applying Under Presumption? <input type="checkbox"/> Yes <input type="checkbox"/> No

The Virginia Retirement System (VRS) determines eligibility for the Virginia Line of Duty Act (LODA). This form must be completed for each Line of Duty claim presented on behalf of a LODA-eligible employee or volunteer. LODA can provide, subject to certain conditions and eligibility approval, death or disability benefits including health insurance coverage.

Note: Please read all instructions prior to completing this form. All claims should be submitted as soon as possible. A claim submitted more than five years after death or the onset of disability will not be eligible for coverage.

PART A. PREPARER INFORMATION (IF DIFFERENT THAN CLAIMANT)

3. Name (First, Middle Initial, Last)	
4. Relationship to Claimant	
5. Phone Number	6. Email Address

PART B. CLAIMANT INFORMATION

7. Name (First, Middle Initial, Last)	8. Social Security Number
9. Address (Street, City, State and ZIP+4)	10. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
11. Marital Status at Time of Incident <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Birth Date
13. Phone Number	14. Retirement Date (if applicable) 15. Email Address

PART C. CLAIMANT'S EMPLOYMENT INFORMATION AT TIME OF INCIDENT (Completed by Employer)

16. Name and Mailing Address of Employing Agency, Organization or Unit	
17. Employer HR Contact Name	18. Employer HR Contact's Email Address
19. Employer HR Contact's Phone Number	20. Date of Original Employment
21. Was claimant performing in the line of duty at time of injury or death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	22. Claimant's Position
23. Claimant's Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (specify) _____	
24. Claimant's Most Recent Annual Salary \$	



25. SSN

PART D. REPORT OF INCIDENT

26. Date of Incident

27. If known, provide name and address of each witness to the incident, if applicable, if not provided in documentation below.

28. What illness or injury caused the disability or death?

29. List the name and address of any physicians the claimant has seen in the past year related to the disability:

<u>Name</u>	<u>Address</u>	<u>Reason for Visit</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

30. Additional Information For Disability Claims Only

- a. Does claimant plan to apply for work-related disability benefits? Yes No
- b. Does claimant plan to apply for Workers' Compensation benefits? Yes No

PART E. REQUIRED REPORTS AND DOCUMENTATION

A copy of each report or document listed below is required for processing this claim. Enter a checkmark next to each document being attached to this form.

For all claims, include copies of:

- Accident/Incident Report
- Pre-employment physical report (if applicable)
- Job Description
- Certification of status as volunteer (if applicable)

Additional Information for Death Benefit Claims

- Death Certificate
- Coroner's report
- Will
- Medical information to support claim in case of presumption

Additional Information for Disability Benefit Claims

- Workers' Compensation award, if available
- Physician's Report (LODA-04)
- Medical information to support claim
- Employer Information for LODA Benefits (LODA-05)

31. SSN

PART F. SPOUSE, DEPENDENT AND OTHER BENEFICIARY INFORMATION

(Attach additional copies of this page in your claim to identify additional children, guardians or beneficiaries)

32. Spouse's Name (First, Middle Initial, Last)	33. Birth Date																								
34. Spouse's Address (Street, City, State and ZIP+4)	35. Spouse's Phone Number																								
36. Spouse's Email Address	37. Is spouse a VRS member? <input type="checkbox"/> Yes <input type="checkbox"/> No																								
38. Children <table><tr><td>Name: _____</td><td>Relationship: _____</td></tr><tr><td>Address: _____</td><td>Birth Date: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr><tr><td>Name: _____</td><td>Relationship: _____</td></tr><tr><td>Address: _____</td><td>Birth Date: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr><tr><td>Name: _____</td><td>Relationship: _____</td></tr><tr><td>Address: _____</td><td>Birth Date: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr></table>		Name: _____	Relationship: _____	Address: _____	Birth Date: _____	Email Address: _____	Phone Number: _____	Name: _____	Relationship: _____	Address: _____	Birth Date: _____	Email Address: _____	Phone Number: _____	Name: _____	Relationship: _____	Address: _____	Birth Date: _____	Email Address: _____	Phone Number: _____						
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Email Address: _____	Phone Number: _____																								
39. Additional Information for Death Benefit (Do not complete if applying for disability benefits) Did Decedent leave a will? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, attach a copy of the will.) Legal Guardianship – If a legal guardian has been appointed for any of the children listed above, provide guardianship information and documentation: <table><tr><td>Guardian: _____</td><td>Child: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr><tr><td colspan="2">Address: _____</td></tr><tr><td>Guardian: _____</td><td>Child: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr><tr><td colspan="2">Address: _____</td></tr></table> Other Beneficiaries – If there is no surviving spouse or children, list all other beneficiaries to the death benefit (e.g. parents, siblings, grandchildren): <table><tr><td>Beneficiary: _____</td><td>Relationship: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr><tr><td colspan="2">Address: _____</td></tr><tr><td>Beneficiary: _____</td><td>Relationship: _____</td></tr><tr><td>Email Address: _____</td><td>Phone Number: _____</td></tr><tr><td colspan="2">Address: _____</td></tr></table>		Guardian: _____	Child: _____	Email Address: _____	Phone Number: _____	Address: _____		Guardian: _____	Child: _____	Email Address: _____	Phone Number: _____	Address: _____		Beneficiary: _____	Relationship: _____	Email Address: _____	Phone Number: _____	Address: _____		Beneficiary: _____	Relationship: _____	Email Address: _____	Phone Number: _____	Address: _____	
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Email Address: _____	Phone Number: _____																								
Address: _____																									

40. SSN

PART F. SPOUSE, DEPENDENT AND OTHER BENEFICIARY INFORMATION (CONTINUED)

41. Required Documentation

A copy of each report or document listed below is required for processing this claim. Enter a checkmark next to each document being attached to this form:

- Birth certificates for the spouse and each child, if applicable
- Order of Adoption, if birth certificate not available for adopted children
- Marriage License, if applicable
- Divorce Decree, if applicable

PART G. CERTIFICATION

Employer/Volunteer Department Certification

By signing below, I acknowledge that the following information is correct to the best of my knowledge, information and belief:

- The individual identified in this claim was, as applicable: 1) employed by the organization for which I am a representative on the date of the incident that caused such individual's disabling condition or death, or 2) an active volunteer of a fire department or emergency medical services agency.
- On the date of the incident that caused the disabling condition or death, the individual identified in this claim was employed or volunteering in the LODA-eligible position listed in Part C of this form.
- If the organization for which I am a representative wishes to provide any information that may assist VRS in making a Line of Duty Act eligibility determination, I understand it must be provided to VRS within 30 days of VRS' receipt of the claim.

Authorized Signer's Printed Name

Authorized Signature

Authorized Signer's Email Address

Phone Number

Date

Claimant/Preparer Certification

By signing below, I acknowledge that the information provided on this form is correct to the best of my knowledge, information and belief, and that I agree to the following terms:

- The information contained in this document that I am submitting to VRS is accurate and up to date.
- If I am submitting this claim on behalf of an individual who was injured in the line of duty, I have express permission from such individual or appropriate legal authority to submit this claim on his or her behalf.
- If I am submitting this claim on behalf of an individual who was killed in the line of duty, I i) am a representative of the employer for which such individual worked on the date of his disability or death, ii) am a spouse or dependent age 18 or older of such individual, or iii) have express permission from such individual's spouse and dependents.
- I have read and understand the instructions that accompany this form.
- VRS, the Department of Human Resource Management (DHRM) and related third parties may use information submitted in this claim or in relation to this claim in any way necessary for the purpose of making an eligibility determination or administering benefits under the Line of Duty Act.
- VRS, DHRM and any physician, agency, or other individual or organization may disclose and receive medical records relating to the injuries or death associated with this claim for the purpose of making an eligibility determination or administering benefits under the Line of Duty Act.

Claimant/Preparer Printed Name

Claimant/Preparer Signature (if dependent is a minor, parent must sign)

Email Address

Phone Number

Date

To avoid processing delays, ensure this form is complete and all required documentation is attached.

Submit the form to:

**Virginia Line of Duty Act
Virginia Retirement System
P.O. Box 2500
Richmond, VA 23218-1500**

COMPLETING THE CLAIM FOR LINE OF DUTY ACT (LODA) BENEFITS

Both the employer and employee are responsible for completing this form. All claims should be submitted as soon as possible. Claims submitted more than five years after death or the onset of the disability will not be eligible for coverage. Please read the instructions carefully.

When submitting a claim, it is important to provide all required documents. Claims submitted for LODA benefits must be reviewed by the Virginia Retirement System (VRS) Medical Review Board. If you do not submit all required documents, VRS is unable to submit the file to the Medical Review Board. This will delay eligibility determination.

Completing the Claim for Line of Duty Act (LODA) Benefits

(To avoid processing delays, print or type the information and ensure all items are completed.)

Box 1: Please choose the correct option to identify the claim category.

Box 2: If the death or disability occurred in the line of duty, please check "no." However, certain deaths or disabilities may not occur directly in the line of duty, but may be considered to have occurred in the line of duty due to certain presumptive causes. These causes include respiratory disease, hypertension, heart disease, certain cancers, and infectious diseases. Certain presumptive causes are applicable only to certain types of employees. If the death or disability did not occur directly in the line of duty and is attributable to respiratory disease, hypertension, heart disease, certain cancers, or infectious disease, please check "yes." Additional information may be required to determine eligibility for a presumptive claim.

Part A: Preparer Information

Enter the preparer's information in Part A if you are assisting a LODA-eligible employee and/or beneficiaries to complete the claim. The person listed as the preparer may be used as a point of contact during claim processing.

Part B: Claimant Information

Enter personal information for the LODA-eligible employee or volunteer for whom this claim is being submitted. The retirement date in box 14 is only required if "yes" was selected in box 2.

Part C: Claimant's Employment Information at Time of Incident

Enter employment information for the LODA-eligible employee or volunteer for whom this claim is being submitted. It is important that this section be completed by the employer who employed the LODA-eligible employee or volunteer at the time of the incident. Please provide contact information for Human Resources to assist with verification of employment information.

Part D: Report of Incident

- Boxes 26-28: Enter information about the incident. If all of the information responsive to these boxes is included in the incident report, please insert "See incident report." If you would like to provide information in addition to what can be found in the incident report, please use these boxes or note additional attachments.
- Box 29: *Required for disability claims.* Please provide information about the disability and any doctor visits in the past 12 months. Please provide a completed Physician's Report (LODA-04) from each doctor you identify.
- Box 30: If this is a disability claim, the claimant may be eligible for other work-related disability benefits. Please indicate if the claimant plans to apply for other work-related disability benefits with VRS. Additional forms are required to obtain these benefits. More information can be found on the VRS website (www.varetire.org/members/disability/vrs/work-related.asp).

Part E: Required Reports and Documentation

Accident/Incident Report

You must attach the accident or incident report with this claim, if applicable.

Pre-Employment Physical Report

If you selected "yes" in box 2 and the employer required the claimant to take a pre-employment physical, you must submit the pre-employment physical report.

Certification of Status as Volunteer

If the claimant is a volunteer, provide information from the fire department or rescue squad recognizing the volunteer status.

Will

If a will is available, provide it to VRS for a death claim. In the absence of a will, VRS will determine the heirs at law based on the order of precedence defined in *Code of Virginia*.

Workers' Compensation Award

A Workers' Compensation award is not required for determining eligibility under Line of Duty Act. This information may be used to determine eligibility for other benefits programs managed at VRS.

Medical Information to Support Claim

You may provide additional medical information to support your claim in electronic or paper format.

Physician's Report (LODA-04)

This form allows the claimant's physician to provide VRS with information about the disabling condition. Give this form to the physician and ask that it be completed and submitted directly to VRS. The physician must also submit written diagnostic, objective findings to substantiate the diagnosis. The LODA-04 can be found on the LODA website (www.valoda.org).

It is in your interest to choose an authorized medical professional who will cooperate with the VRS process. It is the physician's responsibility to do his or her best to fully document the disabling condition so that the Medical Board understands how the condition impacts job performance. The Medical Board will not evaluate the claimant personally. The physician's documentation may have an impact on whether the claim is approved.

Note: The claimant is responsible for medical bills. Remember that VRS is not responsible for payment of fees to the physician for providing any medical information.

Employer Information for LODA Benefits (LODA-05)

The form must be completed to provide information about the position. The form is completed by the employer or the organization for which the claimant volunteers. The LODA-05 can be found on the LODA website (www.valoda.org).

Part F: Spouse, Dependent and Other Claimant Information

Boxes 32-36: Enter personal information for eligible spouse of the LODA-eligible employee or volunteer.

Box 37: Indicate if the spouse is a VRS member.

Box 38: Enter personal information of each dependent including name, address, email address, birth date and phone number. Also include the relationship of each dependent to the LODA-eligible employee or volunteer (e.g., son, step-daughter).

Dependent children include natural and legally adopted children of the LODA-eligible employee or volunteer or of the eligible spouse. Natural children must have been born as the result of a pregnancy that occurred before the LODA-eligible employee or volunteer's disability or death; adopted children must have been legally adopted or the subject of a pre-adoptive agreement before the LODA-eligible employee or volunteer's disability or death.

Box 39: Completed only for death benefits.

Include a readable copy of all birth certificates, marriage licenses, divorce decrees and other supporting documentation. If a birth certificate does not include the individual's full given name and birth date, you must provide other legal documentation.

You may make copies of Part F as needed to list additional children, guardians or beneficiaries. Include the additional page when submitting your claim.

Part G: Certification

Employer/Volunteer Department Certification

The certification section must be signed and dated by an authorized agent or representative of the employer.

Claimant/Preparer Certification

The certification section must be signed and dated by the responsible party.

The claim is not complete and valid unless both certifications are signed and dated. An incomplete claim may delay the eligibility determination and receipt of LODA benefits.

Provisions related to the Virginia Line of Duty Act are set out in Title 9.1 as well as other applicable law.