Service-Connected Death Allowance Application

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SECTION 1 Information About Qualified Beneficiary or Guardian of Minor Beneficiaries

Qualified Beneficiary or Guardian Name (First Name, Middle Initial, Last Name)

Social Security Number

Physical Home Address

City

State

Zip

Home/Cell Phone

Work Phone

Personal Email Address

Your Relation to the Deceased ACERA Member

Select ONE:

- ○ Spouse
- ○ State-Registered Domestic Partner
- ○ Alameda County Domestic Partner
- ○ Unmarried Child or Children, Age 18-21, Enrolled Full-Time in an Accredited School
- ○ Guardian of Qualified Minor Child or Minor Children Who Will Receive Death Allowance

To qualify for an allowance, children must be either (a) unmarried and under age 18, or (b) unmarried, enrolled full-time in an accredited school and under age 22.

Claims for children under 18 must be pursued by a court appointed guardian.

Names and Dates of Birth of Minor Children Who Will Receive Death Allowance

Name (First Name, Middle Initial, Last Name) Date of Birth

Name (First Name, Middle Initial, Last Name) Date of Birth

Name (First Name, Middle Initial, Last Name) Date of Birth

Name (First Name, Middle Initial, Last Name) Date of Birth

Name (First Name, Middle Initial, Last Name) Date of Birth

Put your name and date at the top of every page.

Qualified Beneficiary or Guardian Name (First Name, Middle Initial, Last Name) | Date (mm/dd/yyyy)

SECTION 2 Information About the Deceased ACERA Member

Name of Deceased ACERA Member (First Name, Middle Initial, Last Name)

Social Security Number | Date of Death

Conditions Regarding the ACERA Member's Death

Please describe the conditions that caused the member's death and explain why you contend the death was service-connected—i.e., a result of injury or disease arising out of and in the course of the member's employment, and such employment contributed substantially to the member's death. Provide any information you believe is relevant and attach additional pages if necessary.

Detail Conditions

Safety Member Service-Connected Death Presumptions (Optional)

If the deceased member was not a Safety Member (e.g., sheriff's deputy or probation officer) or you are not asserting a service-connected death presumption, you may skip this question.

For deceased Safety Members who had one or more of the ailments listed below, such ailments may be presumed to be service-connected. Some of the presumptions are subject to additional conditions. Check any of the below boxes that you believe may have contributed to the member's death, so that ACERA staff can help you determine if a presumption may apply. When a presumption applies, the burden of proof shifts to the employer to prove the death was not service-connected, instead of you having the burden to prove the death was service-connected.

Mark one or more conditions you wish to assert:

- ☐ Heart trouble
- ☐ Cancer
- ☐ Blood-borne infectious disease
- ☐ Exposure to biochemical substances
- ☐ Post-traumatic stress disorder
- ☐ Tuberculosis
- ☐ Meningitis
- ☐ Skin cancer
- ☐ Lyme disease
- ☐ Lower back impairments
- ☐ Hernia
- ☐ Pneumonia

Death Certificate

Please attach a copy of the deceased ACERA member's death certificate.

Qualified Beneficiary or Guardian Name (First Name, Middle Initial, Last Name) | Date (mm/dd/yyyy)

SECTION 2

Information About the Deceased ACERA Member (continued)

Physicians Seen By Member In Five Years Before Death

Was the deceased member examined or treated by any health care provider for any reason, within the five years immediately before death?

☐ Yes ☐ No

If yes, for each such provider, please state: (a) name; (b) address; (c) the date(s) of the examination or treatment (Note: a date range is sufficient, for example: 08/16/23 – present, or 09/23 – 01/23); and (d) a description of each symptom, complaint, or other condition for which you were examined or treated. (Do not refer to medical records.) Attach additional pages if necessary to provide information for all providers.

Health Care Provider Name | Date(s) of Examination or Treatment

Address

Description of Complaint, Symptom, Condition

Health Care Provider Name | Date(s) of Examination or Treatment

Address

Description of Complaint, Symptom, Condition

Health Care Provider Name | Date(s) of Examination or Treatment

Address

Description of Complaint, Symptom, Condition

Health Care Provider Name | Date(s) of Examination or Treatment

Address

Description of Complaint, Symptom, Condition

Put your name and date at the top of every page.

Qualified Beneficiary or Guardian Name (First Name, Middle Initial, Last Name)	Date (mm/dd/yyyy)

SECTION 2

Information About the Deceased ACERA Member (continued)

Medical Records

Please attach relevant records that relate to your contention that the member's death is service-connected—i.e., the result of an injury or disease arising out of and in the course of the member's employment, and such employment contributed substantially to such injury or disease. These must include, at minimum:

- Copies of all medical reports and records related to the member's death.
- Copies of all medical reports and records related any condition that you contend contributed to the member's death.
- Copies of any workers' compensation documents related to the member's death or an injury or illness that you contend contributed to the member's death.

You may provide any additional records that are not described above if you believe those additional records support your application for service-connected benefits.

ACERA or the employer may request, and you must provide, any other records deemed necessary to process this application.

SECTION 3

Qualified Beneficiary or Guardian Signature

Qualified Beneficiary or Guardian Signature	Date (mm/dd/yyyy)