PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
POLICE AND FIREMENS' RETIREMENT SYSTEM
OF NEW JERSEY
(609) 292-7524 TDD (609) 292-7718
www.nj.gov/treasury/pensions

ELIZABETH MAHER MUOIO
State Treasurer

ED DONNELLY
Chairman, PFRSNJ

PFRS APPLICATION FOR ACCIDENTAL DEATH BENEFITS

DUE TO COVID-19

In accordance with P.L. 2020, c.54 (Chapter 54), an Act concerning eligibility for Accidental Death benefits for certain members of the Police and Firemen's Retirement System (PFRS), this application allows certain eligible beneficiaries of PFRS members the right to file for an Accidental Death benefit due to exposure to the SARS-CoV-2 virus during the course of performing their job duties.

I hereby submit this statement to attest that the deceased member was exposed to the SARS-CoV-2 virus during the public health emergency in the State of New Jersey declared by the Governor in Executive Order 103 of 2020 and as extended, and developed symptoms of COVID-19 and died as a result, as described below.

PART ONE - MEMBER INFORMATION *(To be completed by the claimant)*

Deceased Member Information:

Name: _____ Membership Number: _____

Date of Birth: _____ Social Security Number: _____

I ATTEST THAT:

- ☐ The member's death is attributable to COVID-19, complications therefrom or the aggravation or acceleration of a preexisting condition due to COVID-19.
- ☐ The member contracted COVID-19 and his/her death occurred after receiving a positive test result for SARS-CoV-2 during the period of a public health emergency in the State of New Jersey declared by the Governor in Executive Order 103 of 2020 and as extended.
- ☐ The member died as a result of COVID-19, or its complications on _____ (date of death).
- ☐ The member's regular or assigned job duties required him/her to interact, and he/she did so interact, with the public or he/she directly supervised personnel that interacted directly with the public, on any date during the public health emergency in the State declared by the Governor in Executive Order No 103 of 2020, and as extended, and within 14 calendar days prior to the appearance of symptoms consistent with COVID-19 that shall have been confirmed in writing by a licensed health care provider that confirms a positive test result for SARS-CoV-2.

Date of Exposure: _____

Location of Exposure: _____

PART ONE - MEMBER INFORMATION *(Continued)*

Please provide a brief synopsis of how the exposure occurred. Attach additional sheets as necessary.

_____

_____

PART TWO – CLAIMANT INFORMATION

Note: The guardian of the child(ren) under 18 years of age of the deceased member may apply if the member left no surviving widow or widower. Attach additional sheets as necessary.

Claimant's Name: _____ Relationship to Deceased: _____

Claimant's Date of Birth: _____ Social Security Number: _____

Claimant's Address: _____

Email Address: _____ Daytime Phone: _____

By my signature, I attest that I have answered the questions on the *Eligibility Registration Form* truthfully, to the best of my knowledge, information, and belief. Further, I understand that any person who knowingly and willfully makes any false statement, misrepresentation, concealment of fact, or any other act of fraud in submitting this *Eligibility Registration Form* pursuant to the Act concerning eligibility for Accidental Death benefits for members of the PFRS who contract COVID-19 and test positive for SARS-COV-2 to which that person is not entitled is subject to punishment inclusive of civil and/or administrative remedies, as well as criminal prosecution which may provide for punishment of a fine or imprisonment.

Claimant's Signature: _____ Date: _____

State of _____

County of _____

Sworn and Subscribed before member this_____day of

_____, 20__.

(Affix notary stamp here)

_____

Notary Public Signature

My Commission Expires:

_____

PART THREE - PATIENT INFORMATION *(To be completed by the treating physician.)*

Name of Patient: _____ Date of Birth: _____

Date of positive SARS-CoV-2 test: _____ Please attach copy(ies) of test results.

Date of Death: _____

Did you treat the member prior to the COVID-19 diagnosis? _____ Yes _____ No

If yes, for what conditions did you treat the member (include treatment dates)?

_____
_____
_____

Please provide a brief summary explaining your opinion that the member's death was substantially due to his/her contraction of COVID-19. Attach any documentation supporting your opinion.

_____
_____
_____

Name of Medical Provider: _____ Degree:_____

Address: _____

Email Address: _____ Daytime Phone: _____

Specialty: _____ N.J. License No: _____

Signature of Provider: _____ Date: _____

Return Completed Forms To:

New Jersey Division of Pensions & Benefits

Beneficiary Services

P.O. Box 295

Trenton, NJ 08625-0295