

LINE OF DUTY INSURANCE

Please complete the following information in order for the Office of Human Resources to determine your status under Title 18, Chapter 66 of the Delaware Code which regulates Line of Duty insurance.

Name:		Social Security #:				
Marital Status:	Single	Married	Divorced	Separated	Engaged	Other
Date pending finalization if engaged or separated:						
Do you have dependent children:		Yes	No			
Are your parents dependent upon you under IRS regulations:		Yes	No			
Spouse's Name:		Social Security #:				
Spouse's Date of Birth:		Date of Marriage:				
Home Phone #:		Work Phone #:				
Office of Human Resources Use Only			Confirming Initials:			
<input type="checkbox"/> Eligible			<input type="checkbox"/> Ineligible			

Designation or Change of Beneficiary Form

Social Security Number _____

Name of Employee _____
LastFirstMiddle

Name of Employer or Volunteer Fire Dept. _____

In accordance with the conditions of the Line of Duty Benefits as covered in Title 18, Chapter 66, Delaware Code, I hereby revoke any previous beneficiary designation and I hereby direct that any amount of benefit payable at my death be paid to the Beneficiary designated below if living. If more than one beneficiary is designated, payment will be made in equal shares to such of the designated beneficiaries as survive me, unless otherwise provided.

Name of Beneficiary _____ Date of Birth _____
Relationship to me _____

Address of Beneficiary _____

The right is reserved to revoke this designation and to designate new Beneficiaries at any time by filling a new designation or Change of Beneficiary Form.

Date: _____

Signature: _____