FIREFIGHTERS' PENSION & RELIEF FUND
FOR THE CITY OF NEW ORLEANS

3520 General DeGaulle Drive, Suite 3001
New Orleans, Louisiana 70114
Telephone: (504) 366-8102
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APPLICATION FOR PRE-RETIREMENT SURVIVOR BENEFIT BY NAMED BENEFICIARY (NEW SYSTEM FIREFIGHTER)

I hereby apply for any Survivor Benefits payable from the Firefighters' Pension & Relief Fund for the City of New Orleans ("Fund") and agree to be bound by the Louisiana statutes establishing the Fund, La. R.S. 11:3361 *et seq.,* and the Rules and Regulations adopted thereunder by the Board of Trustees of the Fund. I hereby request that the Board of Trustees of the Fund determine my eligibility to receive any Survivor Benefits by reason of the death of the named New System Firefighter below. I understand that this Application will be reviewed by the Board only after my application file is complete and I have provided all requested documentation.

PLEASE COMPLETE FULLY - PRINT OR TYPE ANSWERS, THEN SIGN, DATE AND RETURN THIS FORM TO THE FUND OFFICE.

A. INFORMATION ABOUT DECEASED FIREFIGHTER

Name of deceased Firefighter: ____
Last First Middle

Address: ____
Number & Street City State Zip Code

Social Security Number: ____________________ Date of Birth: ____________________

Age of Firefighter at time of death: ________ (Please submit verification of date of birth, e.g. birth certificate or license, and verification of death, i.e. certified copy of death certificate.)

Date of Employment ____________________ Date Retired (if applicable): ____________________

Date of Termination: ____________________ Date of Death: ____________________

Years of Service of deceased Firefighter at time of death: ____________________

If you contend the Firefighter suffered death in the line of duty, please identify direct cause of death (you should note what duties the Firefighter was performing, what injury he sustained and how he died).

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(If you need more space, please attach a supporting letter.)

Does the Firefighter have child(ren) under the age of 18 **or** who are totally or permanently disabled for life?

☐ NO ☐ YES If **YES**, the child(ren) may be entitled to survivor benefits. Please complete an Application for Survivor Benefits for Dependent Child for each child.

B. INFORMATION ABOUT NAMED BENEFICIARY

I certify that I am the Named Beneficiary of the deceased Firefighter and hereby apply for the Survivor Benefits checked below, payable to me by reason of the death of the Firefighter.

Name of Named Beneficiary: ____
Last First Middle

Address: ____
Number & Street City State Zip Code

Social Security Number: ____________________ Date of Birth ____________________
(Please submit a copy of your birth certificate and driver's license.)

C. BENEFIT CLAIMED BY NAMED BENEFICIARY

1. **ACTIVE FIREFIGHTERS.** Please make an election under this section only if the deceased Firefighter was still employed by the Fire Department at the time of his death. If the deceased Firefighter was no longer employed by the Fire Department at the time of his death, please proceed to the INACTIVE FIREFIGHTERS Section below.

   a. FIREFIGHTER DIED WHILE ON DUTY. Please select the following Survivor Benefit under this section if the deceased Firefighter died while he was on duty at the time of his death. If he died while he was off duty, please make an election in the FIREFIGHTER WHO DIED WHILE OFF DUTY Section below.

   ☐ **Percentage of the Firefighter's Salary**: I elect to receive the sum of 66 2/3% or 50% of the Firefighter's salary at the time of his death, paid as an annuity, for life (I understand that the percentage I receive will be based on whether the Trustees determine that the Firefighter died from the *immediate effects* of an injury received while on duty or *in a manner other than from the immediate effects* of an injury received while he was on duty).

   b. FIREFIGHTER WHO DIED WHILE OFF DUTY. Please make an election under this section only if the deceased Firefighter died while he was off duty. Please select the following Survivor Benefit:

   ☐ **$1200 Monthly Pension**: I hereby elect to receive a monthly pension benefit of $1,200.

2. **INACTIVE FIREFIGHTERS**. Please make an election under this section only if the deceased Firefighter was not employed by the fire department at the time of his death. Please **select only one** of the following Survivor Benefit:

   ☐ **$1200 Monthly Pension**: I hereby elect to receive a monthly pension benefit of $1,200 (I understand that I may only elect this option if I am a dependent widowed parent of the Firefighter who had worked at least twelve (12) years of service and was at least fifty (50) years of age at his time of death); **OR**

☐ **Lump Sum Accumulated Contributions:** I elect to receive a refund of the Firefighter's Accumulated Contributions, paid to me in a lump sum.

D. ROLLOVER ELECTION. I understand that the refund of the Accumulated Contributions may be eligible to be rolled over to a traditional individual retirement account ("IRA"), ROTH IRA or eligible employer plan. By signing this application, I certify that I have been given a Special Tax Notice Regarding Distribution of Benefits and a Rollover Election form.

I understand that I must notify the Trustees of the Fund, in writing, if the above information should change. I certify that the above information is true and correct to the best of my knowledge and belief.

_______________________________________ _______________________

Signature of Named Beneficiary Date

Date filed with Board of Trustees: ____________________
(To be completed by the Fund Office)

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REVISED 9/16/13