



Illinois Court of Claims

Secretary of State

Illinois Court of Claims, 630 S. College St., Springfield, IL 62756

Application for Death Benefits Pursuant to Line of Duty Compensation Act

Pursuant to provisions of the Line of Duty Compensation Act, application is hereby made for payment of benefits on account of the death of: _____

1. Name of Decedent: _____

2. Address of decedent's Illinois residence at time of death: _____

3. Address at Time of Entry into the U.S. Armed Forces (if on active duty as an Armed Forces member): _____

4. Place of Birth: _____

5. Date of Death: _____

6. Date of Injury Resulting in Death: _____

7. Branch of Service (if on active duty as an Armed Forces member): _____

8. Employer and Employer's Address (if not an Armed Forces member): _____

9. Rank and Title of Position or assignment in which decedent was serving at time of death or at time of injury resulting in death: _____

10. Decedent's Social Security Number: _____

11. Name(s), Address(es) and Social Security Number(s) of all beneficiaries designated by decedent on Line of Duty Compensation Act Designation of Beneficiary Form for receipt of benefits:

Name	Address	Social Security Number	\$ amount or % share

12. Attach a copy of Line of Duty Designation of Beneficiary form: _____

13. For claims on deaths of Armed Forces members on active duty, attach copies of the following Department of Defense documents (if available):

- A. Report of Casualty (DD Form 1300)
- B. Certificate of Death (DD form 2064) (if available)
- C. Record of Emergency Data (DD Form 93) (if available)
- D. Servicemember's Group Life Insurance Election and Certificate (SGLV8222)

14. If the decedent left a will, please attach a copy of it. Provide social security numbers and current addresses of every beneficiary designated in the will.

15. Attach copies of any other form(s) on which decedent designated beneficiaries for receipt of death benefits
Provide Social Security Number of each beneficiary designated.
16. Decedent's Marital Status at time of death: _____
17. (If applicable) Name, Address, Phone Number and Social Security Number of decedent's surviving spouse:

18. Did decedent have children? Yes No
19. (If applicable) Name(s), Address(es), Phone Number(s), Social Security Number(s) and Birthdates of decedent's children

20. Name(s), Address(es), Phone Number(s) and Social Security Number(s) of other parent(s) of child or children listed in 17: _____

21. (If decedent left no surviving spouse or children) Name(s), Address(es), Phone Number(s) and Social Security Number(s) of decedent's surviving parents: _____

22. (If decedent left no surviving spouse, children or parents) Name(s), Address(es), Phone Number(s) and Social Security Number(s) of decedent's next-of-kin and relationship to decedent: _____

23. Attach copies of any other documents (e.g., incident or investigation reports, statements, newspaper articles, obituaries) that explain the circumstances involved in the decedent's death.
24. Attach copies of any other documents that may be relevant or useful in consideration of this claim.
25. (If decedent was on active duty as an Armed Forces member) Name, Address and Phone Number of the Military Casualty Assistance Officer assigned to assist with matters relating to decedent's death: _____

26. (If decedent was not on active duty as an United States Armed Forces member) Name, Title, Employer, Address and Phone Number of decedent's supervisor at time of decedent's death: _____

TO: Court of Claims, State of Illinois
630 S. College St., Springfield, IL 62756

RE: Application for Death Benefits, pursuant to provisions of the Line of Duty Compensation Act relative to the death of:

Name of Decedent

Date of Birth

**Statement of Supervisor, Commanding Officer
or Military Casualty Assistance Officer**

1. Supervisor's Commanding Officer's or Casualty Assistance Officer's Name, Employer, Rank or Title, Address and Telephone Number: _____

2. Decedent's position or assignment at time of death or at time of injury resulting in death:

3. Time decedent began duty or assignment on date of death or on date of injury resulting in death:

4. Approximate time of death or injury resulting in death: _____

5. Statement of circumstances resulting in or events causing the death of a Law Enforcement Officer, Civil Defense Worker, Civil Air Patrol Member, Paramedic, Firefighter, Chaplain, State Employee or Armed Forces member:

6. Attach copies of all documents (e.g., incident or investigation reports, statements, newspaper articles, obituaries, Military Report of Casualty (DD Form 1300), death certificate), which explain the circumstances involved in decedent's death.

7. Is there any indication, inference or evidence that the death or injury resulted from the willful misconduct or intoxication of the decedent? Yes No

If yes, state circumstance(s) and Name(s) and Address(es) of witnesses or persons having knowledge of willful misconduct or intoxication: _____

Signature

1. Return original and five copies of Application for Death Benefits and this form, and other materials to substantiate the claim, to the address below. Copies may be Xeroxed.
2. Be sure the Application for Benefits is signed and notarized.
3. Be sure to include Claimant's Social Security Number.
4. Be sure the application is filled out completely.

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