Georgia State Firefighters' Association

LINE OF DUTY DEATH BENEFIT
CLAIM APPLICATION
AMOUNT OF BENEFIT: $1,000.00

DATE SUBMITTED:	NAME OF DECEASED MEMBER:

INFORMATION ON DECEDENT:

DATE OF BIRTH:____/_____/_____ SOCIAL SECURITY # _____

ADDRESS_____

_____

FIRE DEPARTMENT INFORMATION: MEMBERSHIP EXPIRATION DATE_____

NAME_____TELEPHONE_____

ADDRESS_____

_____

FIRE CHIEF NAME_____COUNTY_____

GIVE DETAILS ON LINE OF DUTY DEATH: DATE OF DEATH_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

INFORMATION ON PERSON SUBMITTING CLAIM:

NAME_____RELATIONSHIP TO DECEDENT_____

ADDRESS_____

_____