Please return this application to the Retirement System in an envelope marked "Personal and Confidential, Mail Drop 7-1"

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001

RECEIVED

Application for Accidental Death Benefit

RS 6046

(Rev. 12/13)

INSTRUCTIONS: Please print plainly or type. The application must be signed and notarized on reverse side.
Please call our Call Center at 1-866-805-0990 if you need help completing this application.

1. NAME OF DECEASED MEMBER:	**2. SEX:** ☐ **M** ☐ **F**	**3. SOCIAL SECURITY NUMBER*:**
4. ADDRESS:		**5. REGISTRATION NUMBER:**
		6. DATE OF BIRTH / /
7. TELEPHONE NUMBERS: **HOME (** **)** **WORK (** **)** **CELL (** **)**		**8. EMPLOYER:**
9. PAYROLL TITLE		**10. DATE OF DEATH**
11. FOR UNITED STATES TAX WITHHOLDING AND REPORTING PURPOSES (PLEASE CHECK ONE), **I AM A:** ☐ **U.S. CITIZEN** ☐ **RESIDENT ALIEN** ☐ **NONRESIDENT ALIEN**		

12. LIST BELOW ALL DOCTORS WHO TREATED (The last box to name doctor who performed autopsy.)

Primary Care Physician	Doctor	Doctor
Internal Med/Family Practitioner	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code
Doctor	Doctor	Autopsy Doctor
Medical Speciality	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

13. LIST BELOW ALL HOSPITALS WHERE DECEASED WAS TREATED, IF ANY. (Use additional sheets if required)

Hospital	**Dates of Admission**	Hospital	**Dates of Admission**
Street		Street	
City, State and Zip Code		City, State and Zip Code	
Hospital	**Dates of Admission**	Hospital	**Dates of Admission**
Street		Street	
City, State and Zip Code		City, State and Zip Code	

14. THE FOLLOWING PERSON(S) WITNESSED THE ACCIDENT:

Witness Name	Witness Name	Witness Name
Date Witnessed	Date Witnessed	Date Witnessed
Witness Address	Witness Address	Witness Address
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

15. DATE OF ACCIDENT, WHERE ACCIDENT OCCURRED, DESCRIPTION OF THE ACCIDENT (Use additional sheets if required)

16. INFORMATION ABOUT THE APPLICANT

Relationship to deceased _____. I was born on _____ , _____ .

If spouse, married to deceased on _____ , _____ .

17. LIST ALL CHILDREN OF DECEASED MEMBER

Name	Date of Birth	Sex	Name	Date of Birth	Sex

I attach Death Certificate, documentary evidence of my birth, Marriage Certificate and documentary evidence of the birth of the above named children.

18. HAVE YOU MADE THE APPLICATION FOR WORKERS' COMPENSATION BENEFITS? ☐ Yes ☐ No

ARE YOU RECEIVING WORKERS' COMPENSATION BENEFITS? ☐ Yes ☐ No Claim No. _____

19. I do hereby waive the confidential character of any records, reports or data relating to the member's mental or physical condition and hereby authorize the release of all such information by physicians, institutions and agencies including the **Social Security Administration** and the **Veterans Administration,** to the Medical Board of the New York State and Local Retirement System. Records, reports or data shall include, but not be limited to, a Social Security Disability Award Certificate, Social Security Form 831, HIV related, drug abuse and alcoholism information. This authority waives any rights of privacy between the deceased and their physicians, institution or agency. A copy of this waiver may be used in lieu of the original.

I certify that the information contained on this form is true.

_____ _____

Name / (Please Print) Signature (Sign Name in Full)

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

NOTARY PUBLIC (Please sign and affix stamp)

***NOTE**: In accordance with the Federal Privacy Act of 1974 you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Section 11, 34, 311 and 334 of the Retirement and Social Security Law. Your number will be used in identifying your retirement records and in the administration of the Retirement System.

PERSONAL PRIVACY PROTECTION LAW – The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member Services, NYS and Local Retirement Systems, Albany, NY 12244; 518-474-7736.