

State of New Jersey • Department of the Treasury  
**DIVISION OF PENSIONS & BENEFITS — CLAIMS**  
P.O. Box 295, Trenton, NJ 08625-0295  
**APPLICATION FOR ACCIDENTAL DEATH BENEFIT**  
**DUE TO COVID-19**

In accordance with P.L. 2020, c.54 (Chapter 54), an Act concerning eligibility for Accidental Death benefits for certain members of the State Police Retirement System (SPRS) and First Responders enrolled in the Public Employees' Retirement System (PERS), this application allows certain eligible beneficiaries of SPRS and PERS First Responders members the right to file for an Accidental Death benefit due to exposure to the SARS-CoV-2 virus during the course of performing their job duties.

I hereby submit this statement to attest that the deceased member was exposed to the SARS-CoV-2 virus during the public health emergency in the State of New Jersey declared by the Governor in Executive Order 103 of 2020 and as extended, and developed symptoms of COVID-19 and died as a result, as described below.

## PART 1 — DECEASED MEMBER INFORMATION

Name \_\_\_\_\_ Membership Number \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Exposure \_\_\_\_/\_\_\_\_/\_\_\_\_ Location of Exposure \_\_\_\_\_

Please provide a brief synopsis of how the exposure occurred. Attach additional sheets as necessary. \_\_\_\_\_

## PART 2 — CLAIMANT INFORMATION

**Note:** The guardian of the child(ren) under 18 years of age of the deceased member may apply if the member left no surviving widow or widower. Attach additional sheets as necessary.

Claimant's Name \_\_\_\_\_ Relationship to Deceased \_\_\_\_\_

Claimant's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Claimant's Address \_\_\_\_\_

*Street* *City* *State* *Zip*

Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

I ATTEST THAT:

- ☐ The member's death was attributable to COVID-19, complications there from or the aggravation or acceleration of a preexisting condition due to COVID-19.
- ☐ The member contracted COVID-19 and his/her death occurred after receiving a positive test result for SARS-CoV-2 during the period of a public health emergency in the State of New Jersey declared by the Governor in Executive Order 103 of 2020 and as extended.
- ☐ The member died as a result of COVID-19, or its complications.
- ☐ The member's regular or assigned job duties required him/her to interact, and he/she did so interact, with the public or he/she directly supervised personnel that interacted directly with the public, on any date during the public health emergency in the State declared by the Governor in Executive Order No 103 of 2020, and as extended, and within 14 calendar days prior to the appearance of symptoms consistent with COVID-19 that shall have been confirmed in writing by a licensed health care provider that confirms a positive test result for SARS-CoV-2.

By my signature, I attest that I have answered the questions above truthfully, to the best of my knowledge, information, and belief. Further, I understand that any person who knowingly and willfully makes any false statement, misrepresentation, concealment of fact, or any other act of fraud in submitting this *Application for Accidental Death Benefits Due to COVID-19* pursuant to the Act concerning eligibility for Accidental Death benefits for members of the PFRS who contract COVID-19 and test positive for SARS-COV-2 to which that person is not entitled is subject to punishment inclusive of civil and/or administrative remedies, as well as criminal prosecution which may provide for punishment of a fine or imprisonment.

\_\_\_\_\_  
Claimant's Signature

Date \_\_\_\_\_

Part 3 and Part 4 to be completed by the treating physician.

### PART 3 — TREATMENT INFORMATION

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Positive SARS-CoV-2 Test \_\_\_\_/\_\_\_\_/\_\_\_\_ Please attach a copy(ies) of test results. Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you treat the member prior to the COVID-19 diagnosis? ☐ Yes ☐ No

If yes, for what conditions did you treat the member (include treatment dates)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please provide a brief summary explaining your opinion that the member's death was substantially due to his/her contraction of COVID-19.

Attach any documentation supporting your opinion. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PART 4 — PROVIDER INFORMATION

Name of Medical Provider \_\_\_\_\_ Degree \_\_\_\_\_

Address \_\_\_\_\_  
*Street City State Zip*

Email Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Specialty \_\_\_\_\_ N.J. License Number \_\_\_\_\_

\_\_\_\_\_

*Signature of Provider*

*Date*

Mail Completed Application To:

**New Jersey Division of Pensions & Benefits  
Beneficiary Services  
P.O. Box 295  
Trenton, NJ 08625-0295**