PUBLIC SAFETY OFFICER SUPPLEMENTAL BENEFIT PLAN
APPLICATION FOR BENEFITS

Application Type	**Application for Benefits**	**This form must be returned to your agency's Human Resource Department for completion.**
☐ Initial ☐ Extension	• Be sure to answer all questions • Please type or print • Return form to your employer	

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

1. Full name of employee *(Please print)*	2. EIN	3. Agency
4. Position	5. Date of Injury	
6. Description of Injury		
7. Date of Worker's Compensation Eligibility Determination		

Employee Responsibilities

- I have received and understand the eligibility guidelines for this benefit.
- I will report to my employer any changes to my eligibility status for this benefit.
- I will comply with any requests for information pertaining to this benefit from ADOA Risk Management and/or Benefit Services Divisions.
- I authorize my agency, and ADOA Risk Management and Benefit Services Divisions to discuss any pertinent information relative to my eligibility for this benefit.

Certification Statement: I certify that the information given on this application is true and accurate to the best of my knowledge and belief. I understand that such information is subject to verification and I further realize that falsified or fraudulent information may result in the rejection of this application, subsequent termination from the SBP program, or prosecution under the law.

Signature:_____ Date:_____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER – Do not write below this grey line

1. Employee Base Salary	2. Amount of Worker's Compensation Benefit
3. First Date of Absence Due to Injury	4. Date Application Received by Employer

Employer Responsibilities

- I have verified that the employee was employed by my agency at the time of this injury.
- I have verified the employee was on duty on the date of this injury, and that the injury occurred in the line of duty.
- I have verified that the employee has been absent from duty for 30 consecutive calendar days due to this injury.
- I have verified with ADOA Risk Management that this injury meets the guidelines for this benefit.
- I have verified that the employee meets all eligibility criteria for this benefit.
- I will forward a copy of the approved application to both ADOA Risk Management and ADOA Benefit Services Division.

Name of Agency Representative:_____ Contact Number:_____

Signature of Agency Representative:_____ Date:_____

Copy of Approved Application Must be Sent to both:

- ADOA Benefit Services Division, 100 N. 15th Ave, Suite 103, Phoenix, AZ 85007
- ADOA Risk Management, Worker's Compensation, 100 N. 15th Ave, Suite 301, Phoenix, AZ 85007