DES PLAINES FIREFIGHTERS' PENSION FUND
APPLICATION FOR WIDOW/WIDOWER AND/OR DEPENDENT BENEFITS

Name of applicant(s): _____

_____

Relationship(s) to deceased: _____
(spouse/dependent)

Name of deceased: _____ Date of death: _____

I hereby make application for the following type(s) of widow/widower and/or dependent pension from the Des Plaines Firefighters' Pension Fund:

_____ regular surviving spouse benefits (40 ILCS 5/4-114(a))

_____ minor and/or surviving children benefits (40 ILCS 5/4-114(a))

_____ duty-related surviving spouse benefits (40 ILCS 5/4-114(i))

LIVING STATUS

Were you living with the deceased at the time of death? Yes [ ] No [ ]

If no, please state your address and phone number:

Address: _____

Phone Number: _____

Reason for not living with the deceased (indicate separation or divorce, or explain other reasons):

_____

Residence of deceased at time of death: _____

Phone Number: _____

Indicate whether the deceased was an active or retired firefighter or receiving disability benefits at the time of his or her death:

Active _____ Retired _____ Receiving Disability Benefits _____

NATURE OF DEATH

1. If active, was the deceased on duty at the time of his or her death? Yes [ ] No [ ]

2. Cause of death (please attach copy of death certificate): _____

3. Was an official inquiry as to the cause of death made? Yes [ ] No [ ]
   If yes, one copy of the verdict of finding, duly certified, must be attached to this application.

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4. Did the deceased die as a result of sickness, accident, or injury incurred in or resulting from the performance of an act of duty or from the cumulative effects of acts of duty as set forth in Section 4-114(i) of the Illinois Pension Code (40 ILCS 5/4-114(i))?
Yes [ ] No [ ]

5. Was the deceased under physician's care at any time during the last twelve (12) months?
Yes [ ] No [ ] If yes, please give the name, address and phone number of the physician(s):

Name of Physician: _____

Address: _____

Phone Number: _____

Name of Physician: _____

Address: _____

Phone Number: _____

Name of Physician: _____

Address:_____

Phone Number: _____

DEPENDENTS OF DECEASED

Are there any dependent (natural or adopted) children or parents that are entitled to pension benefits from this Fund? Yes [ ] No [ ]

Are there any children that have been conceived but not yet born?Yes [ ] No [ ]

If yes, please indicate the expected date of birth:_____

Are there any dependent (natural or adopted) children who are over the age of 18 and are dependent by reason of a physical or mental disability? Yes [ ] No [ ]

If yes, please list the names, dates of birth, place of birth, and indicate in the case of children whether the children are natural or adopted._____

_____

Also attach copies of birth certificates and/or adoption papers, duly certified. If the child is dependent by reason of a physical or mental disability, please attach a certified copy of the court's order adjudicating the child as a disabled person pursuant to Article XIa of the Probate Act of 1975 (755 ILCS 5/11a-1 *et seq.*).

NAME	DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH (if applicable)	SOCIAL SECURITY NUMBER	RELATIONSHIP	NATURAL or ADOPTED	DEPENDENT BY DISABILITY? (YES/NO)

I certify that the above information and statements are true and correct to the best of my ability.

Applicant's Signature: _____

Date: _____

SUBSCRIBED and SWORN to before me
this ___ day of _____ ,_____.

_____
Notary Public

FOR BOARD USE ONLY

Received by _____ **on** _____
(date)

_____
Signature

The foregoing application having been duly presented and considered by the Board of Trustees of the Des Plaines Firefighters' Pension Fund, the same is hereby Approved/Rejected (circle one) this _____ day of _____, _____ .

BOARD OF TRUSTEES OF THE DES PLAINES FIREFIGHTERS' PENSION FUND

By: _____
President

By: _____
Secretary