

**Georgia State Indemnification Program**

**Application for COVID-19 Death Benefits**

Please type or print

**EMPLOYEE INFORMATION**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle

Last

First

Social Security# \_\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Death \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

At the time of death was (choose one):

\_\_\_\_\_\_\_\_ Paid Full-Time \_\_\_\_\_\_\_\_ Paid Part-Time \_\_\_\_\_\_\_\_\_ Volunteer

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization

Position

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

(Area Code) Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immediate Supervisor

Email:

Name, Address, Email, and Phone Number of Workers Compensation Administrator:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLAIM INFORMATION**

Description of Accident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEATH CLAIMS**

Please list the name, address, and telephone number of the surviving spouse, surviving children, and/or surviving dependents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last date worked by the Public Safety Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Covid-19 Positive Test and/or Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide the following documents with your application:**

1. **Marriage License**
2. **Documentation to verify last day working in the line of duty**
3. **Copy of positive COVID-19 test**
4. **Death Certificate of the deceased applicant**
5. **Birth Certificates of surviving children under the age of 19 and 24 if enrolled in post-secondary education at the time of death**
6. **Copy of the last tax return filed by the decease**

**Applicants who previously supplied these documents in an earlier application do not need to resend the documents. The program DOES need you to complete this application form.**

**PREFERRED METHOD OF PAYMENT** (please check one):

\_\_\_\_\_\_\_\_\_\_\_\_\_ Lump Sum (at present value) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Installments

AUTHORIZED SIGNATURE

I do hereby certify that I am the Surviving Spouse/Child/Guardian of Child/Dependent, and that all information contained herein is accurate and truthful to the best of my knowledge. I authorize the release of any investigative or medical information, including that pertaining to any Workers’ Compensation claim, necessary to process this claim. I do hereby certify that I have disclosed all sources of compensation and authorized the Georgia Department of Administrative Services to receive records associated with such sources of compensation.

This\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION FOR BENEFITS MUST BE RECEIVED BY THE GEORGIA DEPARTMENT OF ADMINISTRATIVE SERVICES WITHIN July 1, 2025 to August 1, 2025.**

Return Completed Application To: Georgia State Indemnification Program

 200 Piedmont Avenue, S.E., Suite 1208 West Tower

 Atlanta, GA 30334

Or Email Application To: Marcellina.Scott@doas.ga.gov, Susan.Setterstrom@doas.ga.gov, and risk.management@doas.ga.gov.