PUBLIC SAFETY OFFICER SUPPLEMENTAL BENEFIT PLAN APPLICATION FOR BENEFITS			
Application Type  Initial Extension	Application for Benefits      Be sure to answer all questions     Please type or print     Return form to your employer		This form must be returned to your agency's Human Resource Department for completion.
THIS SECTION TO BE COMPLETED BY THE EMPLOYEE			
1. Full name of employee <i>(Please prin</i>	t)	2. EIN	3. Agency
4. Position		5. Date of Injury	
6. Description of Injury			
7. Date of Worker's Compensation Eligibility Determination			
Employee Responsibilities			
<ul> <li>I have received and understand the eligibility guidelines for this benefit.</li> <li>I will report to my employer any changes to my eligibility status for this benefit.</li> <li>I will comply with any requests for information pertaining to this benefit from ADOA Risk Management and/or Benefit Services Divisions.</li> <li>I authorize my agency, and ADOA Risk Management and Benefit Services Divisions to discuss any pertinent information relative to my eligibility for this benefit.</li> </ul>			
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			
Employee Base Salary			
1. Employee base Salary		2. Amount of Worker's Compensation Benefit	
3. First Date of Absence Due to Injury		Date Application Received by Employer	
Employer Responsibilities			
<ul> <li>I have verified that the employe</li> <li>I have verified with ADOA Risk</li> <li>I have verified that the employe</li> </ul>	as on duty on the date be has been absent fro Management that this be meets all eligibility o	of this injury, and that th m duty for 30 consecutiv injury meets the guideli riteria for this benefit.	e injury occurred in the line of duty.
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. 15 <sup>th</sup> Ave, Suite 103, Phoenix, AZ 85007  ADOA Risk Management, Worker's Compensation, 100 N. 15 <sup>th</sup> Ave, Suite 301, Phoenix, AZ 85007			