LINE OF DUTY INSURANCE

Please complete the following information in order for the Office of Human Resources to determine your status under Title 18, Chapter 66 of the Delaware Code which regulates Line of Duty insurance.

Name:	Social Security #:
Marital Status: Single Married Divorced Separated Engaged Other	
Date pending finalization if engaged or separated:	
Do you have dependent children: Yes No	
Are your parents dependent upon you under IRS regulations: Yes No	
Spouse's Name:	Social Security #:
Spouse's Date of Birth:	Date of Marriage:
Home Phone #:	Work Phone #:
Office of Human Resources Use Only	Confirming Initials:
❑ Eligible	❑ Ineligible

Designation or Change of Beneficiary Form

Social Security Number _________________________

Name of Employee____
Last First Middle

Name of Employer or Volunteer Fire Dept.

In accordance with the conditions of the Line of Duty Benefits as covered in Title 18, Chapter 66, Delaware Code, I hereby revoke any previous beneficiary designation and I herby direct that any amount of benefit payable at my death be paid to the Beneficiary designated below if living. If more than one beneficiary is designated, payment will be made in equal shares to such of the designated beneficiaries as survive me, unless otherwise provided.

Name of Beneficiary Date of Birth

Relationship to me

Address of Beneficiary

The right is reserved to revoke this designation and to designate new Beneficiaries at any time by filling a new designation or Change of Beneficiary Form.

Date:____ **Signature:**__________________________________