CLAIM FOR LINE OF DUTY ACT (LODA) BENEFITS

VIRGINIA LINE OF DUTY ACT (LODA)
P.O. Box 2500 ◆ Richmond, VA 23218-2500
Toll-free 1-888-827-3847
Fax 1-804-786-9718
www.valoda.org

Clear Form

1. Type of Benefit (Choose one)	❒ Death ❒ Disability
2. Applying Under Presumption?	❒ Yes ❒ No

The Virginia Retirement System (VRS) determines eligibility for the Virginia Line of Duty Act (LODA). This form must be completed for each Line of Duty claim presented on behalf of a LODA-eligible employee or volunteer. LODA can provide, subject to certain conditions and eligibility approval, death or disability benefits including health insurance coverage.

Note: **Please read all instructions prior to completing this form**. All claims should be submitted as soon as possible. A claim submitted more than five years after death or the onset of disability will not be eligible for coverage.

PART A. PREPARER INFORMATION (IF DIFFERENT THAN CLAIMANT)

3. Name (First, Middle Initial, Last)	
4. Relationship to Claimant	
5. Phone Number	**6. Email Address**

PART B. CLAIMANT INFORMATION

7. Name (First, Middle Initial, Last)		**8. Social Security Number**
9. Address (Street, City, State and ZIP+4)		**10. Gender** ❒ Male ❒ Female
11. Marital Status at Time of Incident ❒ Single ❒ Married ❒ Separated ❒ Widowed ❒ Divorced		**12. Birth Date**
13. Phone Number	**14. Retirement Date** (if applicable)	**15. Email Address**

PART C. CLAIMANT'S EMPLOYMENT INFORMATION AT TIME OF INCIDENT (Completed by Employer)

16. Name and Mailing Address of Employing Agency, Organization or Unit	
17. Employer HR Contact Name	**18. Employer HR Contact's Email Address**
19. Employer HR Contact's Phone Number	**20. Date of Original Employment**
21. Was claimant performing in the line of duty at time of injury or death? ❒ Yes ❒ No ❒ Unknown	**22. Claimant's Position**
23. Claimant's Employment Status ❒ Full-time ❒ Part-time ❒ Retired ❒ Volunteer ❒ Other (specify) _____	
24. Claimant's Most Recent Annual Salary **$**	

25. SSN

PART D. REPORT OF INCIDENT

26. Date of Incident

27. If known, provide name and address of each witness to the incident, if applicable, if not provided in documentation below.

28. What illness or injury caused the disability or death?

29. List the name and address of any physicians the claimant has seen in the past year related to the disability:

Name	Address	Reason for Visit

30. Additional Information For Disability Claims Only

a. Does claimant plan to apply for work-related disability benefits? ❒ Yes ❒ No

b. Does claimant plan to apply for Workers' Compensation benefits? ❒ Yes ❒ No

PART E. REQUIRED REPORTS AND DOCUMENTATION

A copy of each report or document listed below is required for processing this claim. Enter a checkmark next to each document being attached to this form.

For *all* claims, include copies of:

- ❑ Accident/Incident Report
- ❑ Pre-employment physical report (if applicable)
- ❑ Job Description
- ❑ Certification of status as volunteer (if applicable)

Additional Information for Death Benefit Claims

- ❑ Death Certificate
- ❑ Coroner's report
- ❑ Will
- ❑ Medical information to support claim in case of presumption

Additional Information for Disability Benefit Claims

- ❑ Workers' Compensation award, if available
- ❑ Physician's Report (LODA-04)
- ❑ Medical information to support claim
- ❑ Employer Information for LODA Benefits (LODA-05)

31. SSN

PART F. SPOUSE, DEPENDENT AND OTHER BENEFICIARY INFORMATION

(Attach additional copies of this page in your claim to identify additional children, guardians or beneficiaries)

32. **Spouse's Name** (First, Middle Initial, Last)	33. **Birth Date**
34. **Spouse's Address** (Street, City, State and ZIP+4)	35. **Spouse's Phone Number**
36. **Spouse's Email Address**	37. **Is spouse a VRS member?** ❒ Yes ❒ No

38. Children

Name: _____ Relationship: _____

Address: _____ Birth Date: _____

Email Address: _____ Phone Number: _____

Name: _____ Relationship: _____

Address: _____ Birth Date: _____

Email Address: _____ Phone Number: _____

Name: _____ Relationship: _____

Address: _____ Birth Date: _____

Email Address: _____ Phone Number: _____

39. Additional Information for Death Benefit (Do not complete if applying for disability benefits)

Did Decedent leave a will? ❒ Yes ❒ No (If Yes, attach a copy of the will.)

Legal Guardianship – If a legal guardian has been appointed for any of the children listed above, provide guardianship information and documentation:

Guardian: _____ Child: _____

Email Address: _____ Phone Number: _____

Address: _____

Guardian: _____ Child: _____

Email Address: _____ Phone Number: _____

Address: _____

Other Beneficiaries – If there is no surviving spouse or children, list all other beneficiaries to the death benefit (e.g. parents, siblings, grandchildren):

Beneficiary: _____ Relationship: _____

Email Address: _____ Phone Number: _____

Address: _____

Beneficiary: _____ Relationship: _____

Email Address: _____ Phone Number: _____

Address: _____

40. SSN

PART F. SPOUSE, DEPENDENT AND OTHER BENEFICIARY INFORMATION (CONTINUED)

41. Required Documentation

A copy of each report or document listed below is required for processing this claim. Enter a checkmark next to each document being attached to this form:

- ❑ Birth certificates for the spouse and each child, if applicable
- ❑ Order of Adoption, if birth certificate not available for adopted children
- ❑ Marriage License, if applicable
- ❑ Divorce Decree, if applicable

PART G. CERTIFICATION

Employer/Volunteer Department Certification

By signing below, I acknowledge that the following information is correct to the best of my knowledge, information and belief:

- The individual identified in this claim was, as applicable: 1) employed by the organization for which I am a representative on the date of the incident that caused such individual's disabling condition or death, or 2) an active volunteer of a fire department or emergency medical services agency.
- On the date of the incident that caused the disabling condition or death, the individual identified in this claim was employed or volunteering in the LODA-eligible position listed in Part C of this form.
- If the organization for which I am a representative wishes to provide any information that may assist VRS in making a Line of Duty Act eligibility determination, I understand it must be provided to VRS within 30 days of VRS' receipt of the claim.

Authorized Signer's Printed Name	Authorized Signature	
Authorized Signer's Email Address	Phone Number	Date

Claimant/Preparer Certification

By signing below, I acknowledge that the information provided on this form is correct to the best of my knowledge, information and belief, and that I agree to the following terms:

- The information contained in this document that I am submitting to VRS is accurate and up to date.
- If I am submitting this claim on behalf of an individual who was injured in the line of duty, I have express permission from such individual or appropriate legal authority to submit this claim on his or her behalf.
- If I am submitting this claim on behalf of an individual who was killed in the line of duty, I i) am a representative of the employer for which such individual worked on the date of his disability or death, ii) am a spouse or dependent age 18 or older of such individual, or iii) have express permission from such individual's spouse and dependents.
- I have read and understand the instructions that accompany this form.
- VRS, the Department of Human Resource Management (DHRM) and related third parties may use information submitted in this claim or in relation to this claim in any way necessary for the purpose of making an eligibility determination or administering benefits under the Line of Duty Act.
- VRS, DHRM and any physician, agency, or other individual or organization may disclose and receive medical records relating to the injuries or death associated with this claim for the purpose of making an eligibility determination or administering benefits under the Line of Duty Act.

Claimant/Preparer Printed Name	Claimant/Preparer Signature (if dependent is a minor, parent must sign)	
Email Address	Phone Number	Date

To avoid processing delays, ensure this form is complete and all required documentation is attached.

Submit the form to:

Virginia Line of Duty Act
Virginia Retirement System
P.O. Box 2500
Richmond, VA 23218-1500

Informed Consent and Authorization

SSN

Notice to Member.

Your address, birth date, marital status, and similar information as well as your medical information are classified as private data. VRS will not share your private data with any person or entity except pursuant to your Authorization, below, or an order from a court. If you do not provide the information requested by VRS and its claim manager, Managed Medical Review Organization, Inc. (MMRO), you may impede processing of your claim.

A photocopy or facsimile of this Informed Consent and Authorization shall be as valid as the original.

Authorization for VRS and MMRO to release information.

I give my informed consent to and authorize VRS and its third party administrator, MMRO, to provide the information in my VRS disability retirement application file, disability recall or my Line of Duty Act (LODA) claim file, as applicable, to any independent medical examiners, consultants or fact finders retained by VRS or MMRO to assist in evaluation of my application for disability retirement or LODA claim as applicable, my attorney or other authorized agent (if applicable, attorney or agent's Name_____), court reporter, or a court of competent jurisdiction for the purpose of evaluating my disability retirement application, disability recall status or my LODA claim as applicable, and any appeals thereof. This Authorization shall become effective on the date appearing next to my signature below. This consent will remain effective until the evaluation of my disability retirement application, disability recall or LODA claim and any appeals thereof are complete. I understand that I may request a copy of this Authorization. I understand I have the right to revoke this Authorization at any time by notifying MMRO in writing. I understand that revoking this Authorization may impede the processing of my application for disability retirement benefits, disability recall or LODA claim.

HIPAA Authorization for care providers and consultants to release information to VRS and MMRO.

I hereby authorize the use and disclosure of protected health information about me as described below.

i. The following specific person/class of person/facility is authorized to disclose information about me to VRS, MMRO, and my attorney or authorized agent (if applicable): any health care provider, hospital, medical facility, rehabilitation consultant, or agency, or other organization.

ii. The following person, class of persons, or entity may receive disclosure of protected health information about me: VRS, MMRO and any independent medical examiners, consultants or fact finders retained by VRS or MMRO to assist in evaluation of my application for disability retirement benefits, disability recall or LODA claim.

iii. The following information may be disclosed: all information with respect to any physical or mental condition and/or treatment of me, including information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse and mental health.

iv. I understand that the information used or disclosed may be subject to re-disclosure by VRS and MMRO as necessary to evaluate my application for disability retirement benefits or LODA claim and to conduct an informal fact-finding proceeding, or judicial review of a case decision under the Virginia Administrative Process Act, and would then no longer be protected by federal privacy regulations.

v. I may revoke this authorization by notifying MMRO in writing of my desire to revoke it. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

vi. My purpose/use of the information is for my application for VRS disability retirement benefits, disability recall or LODA claim.

vii. This authorization expires one year from the date of my signature or upon the final determination of my eligibility for VRS disability retirement benefits, disability recall or LODA benefits, whichever is later.

Member's Printed Name and Signature

Date

Managed Medical Review Organization, Inc.
44090 W. 12 Mile Road, Novi, MI 48377
Telephone: 866-516-6676 Fax: 248-530-7411

COMPLETING THE CLAIM FOR LINE OF DUTY ACT (LODA) BENEFITS

Both the employer and employee are responsible for completing this form. All claims should be submitted as soon as possible. Claims submitted more than five years after death or the onset of the disability will not be eligible for coverage. Please read the instructions carefully.

When submitting a claim, it is important to provide all required documents. Claims submitted for LODA benefits must be reviewed by the Virginia Retirement System (VRS) Medical Review Board. If you do not submit all required documents, VRS is unable to submit the file to the Medical Review Board. This will delay eligibility determination.

Completing the Claim for Line of Duty Act (LODA) Benefits

(To avoid processing delays, print or type the information and ensure all items are completed.)

Box 1: Please choose the correct option to identify the claim category.

Box 2: If the death or disability occurred in the line of duty, please check “no.” However, certain deaths or disabilities may not occur directly in the line of duty, but may be considered to have occurred in the line of duty due to certain presumptive causes. These causes include respiratory disease, hypertension, heart disease, certain cancers, and infectious diseases. Certain presumptive causes are applicable only to certain types of employees. If the death or disability did not occur directly in the line of duty and is attributable to respiratory disease, hypertension, heart disease, certain cancers, or infectious disease, please check “yes.” Additional information may be required to determine eligibility for a presumptive claim.

Part A: Preparer Information

Enter the preparer’s information in Part A if you are assisting a LODA-eligible employee and/or beneficiaries to complete the claim. The person listed as the preparer may be used as a point of contact during claim processing.

Part B: Claimant Information

Enter personal information for the LODA-eligible employee or volunteer for whom this claim is being submitted. The retirement date in box 14 is only required if “yes” was selected in box 2.

Part C: Claimant’s Employment Information at Time of Incident

Enter employment information for the LODA-eligible employee or volunteer for whom this claim is being submitted. It is important that this section be completed by the employer who employed the LODA-eligible employee or volunteer at the time of the incident. Please provide contact information for Human Resources to assist with verification of employment information.

Part D: Report of Incident

Boxes 26-28: Enter information about the incident. If all of the information responsive to these boxes is included in the incident report, please insert "See incident report." If you would like to provide information in addition to what can be found in the incident report, please use these boxes or note additional attachments.

Box 29: *Required for disability claims*. Please provide information about the disability and any doctor visits in the past 12 months. Please provide a completed Physician's Report (LODA-04) from each doctor you identify.

Box 30: If this is a disability claim, the claimant may be eligible for other work-related disability benefits. Please indicate if the claimant plans to apply for other work-related disability benefits with VRS. Additional forms are required to obtain these benefits. More information can be found on the VRS website (www.varetire.org/members/disability/vrs/work-related.asp).

Part E: Required Reports and Documentation

Accident/Incident Report
You must attach the accident or incident report with this claim, if applicable.

Pre-Employment Physical Report
If you selected "yes" in box 2 and the employer required the claimant to take a pre-employment physical, you must submit the pre-employment physical report.

Certification of Status as Volunteer
If the claimant is a volunteer, provide information from the fire department or rescue squad recognizing the volunteer status.

Will
If a will is available, provide it to VRS for a death claim. In the absence of a will, VRS will determine the heirs at law based on the order of precedence defined in *Code of Virginia*.

Workers' Compensation Award
A Workers' Compensation award is not required for determining eligibility under Line of Duty Act. This information may be used to determine eligibility for other benefits programs managed at VRS.

Medical Information to Support Claim
You may provide additional medical information to support your claim in electronic or paper format.

Physician's Report (LODA-04)
This form allows the claimant's physician to provide VRS with information about the disabling condition. Give this form to the physician and ask that it be completed and submitted directly to VRS. The physician must also submit written diagnostic, objective findings to substantiate the diagnosis. The LODA-04 can be found on the LODA website (www.valoda.org).

It is in your interest to choose an authorized medical professional who will cooperate with the VRS process. It is the physician's responsibility to do his or her best to fully document the disabling condition so that the Medical Board understands how the condition impacts job performance. The Medical Board will not evaluate the claimant personally. The physician's documentation may have an impact on whether the claim is approved.

Note: The claimant is responsible for medical bills. Remember that VRS is not responsible for payment of fees to the physician for providing any medical information.

Employer Information for LODA Benefits (LODA-05)
The form must be completed to provide information about the position. The form is completed by the employer or the organization for which the claimant volunteers. The LODA-05 can be found on the LODA website (www.valoda.org).

Part F: Spouse, Dependent and Other Claimant Information

Boxes 32-36: Enter personal information for eligible spouse of the LODA-eligible employee or volunteer.

Box 37: Indicate if the spouse is a VRS member.

Box 38: Enter personal information of each dependent including name, address, email address, birth date and phone number. Also include the relationship of each dependent to the LODA-eligible employee or volunteer (e.g., son, step-daughter).

Dependent children include natural and legally adopted children of the LODA-eligible employee or volunteer or of the eligible spouse. Natural children must have been born as the result of a pregnancy that occurred before the LODA-eligible employee or volunteer's disability or death; adopted children must have been legally adopted or the subject of a pre-adoptive agreement before the LODA-eligible employee or volunteer's disability or death.

Box 39: Completed only for death benefits.

Include a readable copy of all birth certificates, marriage licenses, divorce decrees and other supporting documentation. If a birth certificate does not include the individual's full given name and birth date, you must provide other legal documentation.

You may make copies of Part F as needed to list additional children, guardians or beneficiaries. Include the additional page when submitting your claim.

Informed Consent and Authorization
Enter your SSN, sign and date the authorization and include it with the claim when sending to VRS. This form authorizes Managed Medical Review Organization (MMRO), the VRS Medical Board, to have access to your claim and supporting documents for purposes of medical review.

Part G: Certification

Employer/Volunteer Department Certification
The certification section must be signed and dated by an authorized agent or representative of the employer.

Claimant/Preparer Certification
The certification section must be signed and dated by the responsible party.

The claim is not complete and valid unless both certifications are signed and dated. An incomplete claim may delay the eligibility determination and receipt of LODA benefits.

Provisions related to the Virginia Line of Duty Act are set out in Title 9.1 as well as other applicable law.