**APPENDIX A**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **MONTGOMERY COUNTY FIRE RESCUE SERVICE**  **LENGTH OF SERVICE AWARD PROGRAM**  APPLICATION FOR PAYMENT  (Please Print CEARLY) | | | | | | | | | | | | | | | | | | | |
| Volunteer Name: | | | | | | |  | | | | | | | | | | | | | | | | |
| Volunteer Street Address: | | | | | | |  | | | | | | | | | | | | | | | |
| City: |  | | | | | | | | | State: | | |  | | Zip Code: | | | |  | | | |
| Volunteer Social Security Number: | | | |  | - |  | | - |  | | Volunteer Birth Date: | | |  | | | / |  | | / |  | | |
| Volunteer Primary Phone: | | | |  | | | | | | | | Volunteer Alternate Phone: | |  | | | | | | | | | |
| LFRD/Station: | | | |  | | | | | | | | | | | | | | | | | | | |
| Volunteer Email: | | | |  | | | | | | | | | | | | | | | | | | |
| **TYPE OF PAYMENT REQUEST:** | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | | **New Award – Benefit Eligibility Requirement:** | | | | | | | | | | | | | | | | | | | | | |
| ❑ | 25 Years of Certified Service | | | | | | | | | | | | | # Active Years | | | | | |  | |
| ❑ | 15 Years of Certified Service and age 60 | | | | | | | | | | | | | # Active Years | | | | | |  | |
| ❑ | 10 Years of Certified Service and age 65 | | | | | | | | | | | | | # Active Years | | | | | |  | |
| ❑ | Permanent Disability Benefit | | | | | | | | | | | | | | | | | | | | |

**SURVIVOR TO Fill out this section if requesting Death Benefit and/or Survivor Benefit.**

**THIS IS NOT THE BENEFICIARY DESIGNATION FORM.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ❑ | Surviving Spouse | | | ❑ | Estate | | | | ❑ | Death Beneficiary | | | |
| Beneficiary Name: | | | | |  | | | | | | | | | Gender: | | ❑ | | Male | | ❑ | | | Female |
| Beneficiary Social Security Number: | | | | |  | | - |  | | | - |  | Beneficiary Birth Date: | |  | | / | |  | | / |  | |
| Beneficiary Address: | | | | |  | | | | | | | | | | | | | | | | | | |
| Beneficiary Phone: | | | | |  | | | | | | | | | | | | | | | | | | |
| If spouse, Date of Marriage: | | | | |  | | | | | | | | | | | | | | | | | | |
| Beneficiary Email: | | | | |  | | | | | | | | | | | | | | | | | | |
| **TYPE OF PAYMENT REQUEST (PLEASE CHECK EACH ONE THAT’S APPLICABLE)** | | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | Estate Death Benefit (Will be paid to the Estate if there is no Spouse or Domestic Partner)  ***Please submit a copy of the death certificate*** | | | | | | | | | | | | | | | | | | | | |
| ❑ | Survivor Benefit (1/2 of volunteer’s monthly benefit) – payable to Spouse or Domestic Partner Only. ***Please submit a copy of the death certificate*** | | | | | | | | | | | | | | | | | | | | |
| ❑ | Death Benefit ($5,000) ***Please submit a copy of the death certificate*** | | | | | | | | | | | | | | | | | | | | |
| Volunteer Date of Death: | | | |  | | | | | | | | | | | | | | | | | |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant’s Signature Date**

***Return form to MCFRS LOSAP Administrator, 100 Edison Park Drive, Gaithersburg, MD 20878***

***If you have questions, please call 240-777-2428***