APPENDIX A

MONTGOMERY COUNTY FIRE RESCUE SERVICE
LENGTH OF SERVICE AWARD PROGRAM

APPLICATION FOR PAYMENT
(Please Print CLEARLY)

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		

X _____
Applicant's Signature

X _____
Date

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

LOSAP BENEFICIARY DESIGNATION/CHANGE FORM

Please fill out each section completely.
Return to: LOSAP Administrator, MCFRS, 100 Edison Park Drive, 2nd Floor
Gaithersburg, MD 20878
Telephone: 240-777-2428

Volunteer Information: *Please **print clearly** using black ink*

First Name	MI	Last Name
Social Security Number	Phone Number	
Address		
City	State	Zip Code
Email Address		

Beneficiary Designations: I hereby revoke any previous designations of primary and contingent beneficiary(ies), if any, and designate the following: **Survivor Beneficiary – Must be spouse.**

First Name / Middle Initial / Last Name	Date of Marriage	
Address	Date of Birth	Phone Number
Address (city, state, zip code)	Social Security Number	Email Address

Death Beneficiary – one-time $5,000 payment.
If more than one Death Beneficiary is named, the $5000 payment will be divided between beneficiaries. Beneficiary Description
☐Individual ☐Individuals (Please see page 2 for additional names) ☐Corporation/Organization ☐Trust/Other

First Name / Middle Initial / Last Name	Relationship to Member	
Address	Date of Birth	Social Security Number
Address (city, state, zip code)	Phone Number	Email Address

Trust Designation – Please attach a copy of the Trust Agreement. Complete if a Trust has been named as a Beneficiary in Section 2.

Trustee's Name (First, MI, Last)	Address (include city, state, zip code)

And successor(s) in trust, as Trustee(s)_____ Dated _____ As amended

and executed by me and said Trustee. Title of Agreement _____Date of Agreement _____

X_____
Signature

X_____
Date

MCFRS volunteer must sign and date this form.
The survivor benefit is only payable to a spouse. You may name anyone or any entity as your death benefit beneficiary and you may change your beneficiary at any time by completing a new Beneficiary Designation/Change form. **Payment will be made to the beneficiary. Current benefit for survivors is ½ of the monthly award for life or until the spouse remarries/death.** (Revised 02/2018)

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PAGE 2

Death Beneficiary – one-time $5,000 payment. Additional Beneficiaries
If more than one Death Beneficiary is named, the $5000 payment will be divided between beneficiaries.
Page 2 does not need to be used if only one Death Beneficiary is named.

First Name Middle Initial Last Name	Relationship to Member	
Address	Date of Birth	Social Security Number
Address (city, state, zip code)	Phone Number	Email Address

First Name Middle Initial Last Name	Relationship to Member	
Address	Date of Birth	Social Security Number
Address (city, state, zip code)	Phone Number	Email Address

First Name Middle Initial Last Name	Relationship to Member	
Address	Date of Birth	Social Security Number
Address (city, state, zip code)	Phone Number	Email Address

_____ _____

Page 2 Signature **Date**

MCFRS volunteer must sign and date this form.

The survivor benefit is only payable to a spouse. You may name anyone or any entity as your death benefit beneficiary and you may change your beneficiary at any time by completing a new Beneficiary Designation/Change form. **Payment will be made to the beneficiary. Current benefit for survivors is ½ of the monthly award for life or until the spouse remarries/death.** (Revised 02/2018)

DIRECT DEPOSIT AUTHORIZATION

INSTRUCTIONS: To establish or change a direct deposit to a CHECKING account, attach a voided personal check drawn on the account that will receive the direct deposit and complete Section 1 below. Complete Section 2 if a voided check is not attached or the direct deposit is to be credited to a "Savings Account." Section 2 of this form must be completed by a representative of the financial institution.

SECTION 1 - TO BE COMPLETED BY LOSAP RECIPIENT

Name: _____

Social Security Number: _____

Home Telephone: _____ Work or Cell Telephone: _____

Email: _____

Transaction Type: _____ Enrollment _____ Change (See Note 1-Changes) _____ Cancellation

Account Type: _____ Checking (attach voided check) OR _____ Savings Account (complete Section 2 below)

Financial Institution: _____ Bank Acct # _____

I hereby authorize Montgomery County, Maryland (hereinafter called the "County") to deposit my net salary with the bank named above (hereinafter called the "bank" to credit same to the checking or savings account described on the attached voided check or below. This authorization is to remain in force until the County has received written notification from me of its termination in such time and in such manner as to afford the County and/or the Bank a reasonable opportunity to act upon it.

In the event that the County notifies the Bank that funds to which I am not entitled have been deposited to my account inadvertently, I hereby authorized and direct the Bank to return said funds to the County as soon as possible.

Signature: _____ Date: _____

SECTION 2 – TO BE COMPLETED BY FINANCIAL INSTITUTION

You do not need to complete Section 2 if a voided check is attached to this form.

We, the below-designated financial organization, hereby agree to receive and deposit sums for the payee named herein. We understand that the account number shown for the payee named herein will be included on individual credits to his/her account. We understand that the payee named above has the right to cancel this authorization and we reserve the right to cancel this agreement by notice to the payee. We agree to honor the employee's authorization (above) to return funds deposited in their account inadvertently, when requested by Montgomery County, Maryland.

Financial Institution: _____

Bank Routing Number: _____ Bank Acct # _____

Account Type: _____ Checking OR _____ Savings

_____ _____ _____

SIGNATURE OF BANK OFFICER Date Telephone No.

Return form to: LOSAP Administrator, Public Safety Headquarters, 100 Edison Park Drive, 2nd Floor, Gaithersburg, MD 20878