INCIDENT AND INJURY INFORMATION

Financial Assistance Request #1

**Please note that this request must be submitted by a first level supervisor or an H/R Supervisor.*

Today's Date: ___________ **Department / Agency**: _________________________________

Date of Injury: __________ **Line of Duty Injury?** ☐ **Non-Line of Duty Injury?** ☐

Name of Injured Individual: ____________________________________ **Title / Position:** ___________________

Date of Birth: ______________________ **Email Address:** ____

Is Injured Individual a Full-Time Paid Employee? Yes/No

Years of Service: ____________

Describe Incident and Events of Injury:

**Please submit copy of Department Incident Report or Industrial Claim with request*

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____
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____
____

In Hospital: YES/NO **ICU: YES/NO**

Estimated Hospital Stay: ________________

Estimated Time Off Work: _______________

Does Injured Require Extensive or 24-Hour Care If Not in the Hospital? ___________________________________

Has Injured Individual Worked Any Hours Since Injury (Full Duty or Light Duty)? ___________________________

Has Injured Individual Been Out Of Work For 30 Days Or More? ___________________________

BENEFICIARY INFORMATION

Beneficiary Name (Spouse / Parent): ____

Home Phone: ________________________ **Mobile:** _______________________ **Other:** ___________________

Home Address: ____ **City/St/Zip:** ____________________________

Make Benefit Check To: ___________________________ **Relationship to Injured:** _______________________

Where Shall Payment Be Delivered?: ____

How Many Dependents (Other Than Spouse): _______

Name, Sex, and Date of Birth of Dependents:

**This information is used internally to provide opportunities to dependents such as: summer camp, holiday gift giving, scholarship opportunities, etc.*

1. Name: _______________ Sex: ___ DOB: __________

2. Name: _______________ Sex: ___ DOB: __________

3. Name: _______________ Sex: ___ DOB: __________

4. Name: _______________ Sex: ___ DOB: __________

5. Name: _______________ Sex: ___ DOB: __________

**dependent is that which is adopted, biological, or of which the public safety individual has guardianship*

**if needed please continue information on separate document*

INFORMATION PROVIDED BY

**Must be submitted by a first level supervisor or an H/R Supervisor.*

Your Name: ____ **Title:** ____________________________

Department/Agency: ____

Agency Address: __________________________________ **City/St/Zip:** ________________________

Office Phone: __________________ **Mobile:** __________________ **Other:** _____________________

Email: ____

Your Signature: ____ **Date:** ____________

Second Level Supervisor Name: ____________________________ **Title:** ______________________

Office Phone: __________________ **Mobile:** _________________ **Other:** ______________________

Signature: ____ **Date:** ____________

Department Head/Chief Name: ___________________________ **Email:** ______________________

To submit form by email, send to benefits@100club.org | To Submit by Fax, use (602) 242-1715

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TO BE COMPLETED BY AUTHORIZED 100 CLUB PERSONNEL

Verified/Approved: __________________________ Date: ______ Data ID: _______ Payment ID: ________
Posted: _____________________________________ Date: ______ Check #: _______ Amount: ___________
Denied: ____________________________________ Date: ______