INCIDENT AND INJURY INFORMATION

Financial Assistance Request #2-12

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

Today's Date: _____ Department / Agency: _____ Request #_____

Date of Injury: _____ Line of Duty Injury? ☐ Non-Line of Duty Injury? ☐

Name of Injured Individual: _____

Title / Position: _____

Date of Birth: _____

Is Injured Individual a Full-Time Paid Employee?

Years of Service: _____

Please Provide an Update on Injured Individual's Status:

_____
_____
_____
_____

In Hospital: YES/NO ICU: YES/NO

Has Estimated Time Off Work Changed Since Last Request? _____

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

What Is the Base Pay Amount of the Injured Individual? _____

Is the Injured Individual Able to Receive Ongoing Payments? _____

BENEFICIARY INFORMATION

Beneficiary Name: _____

Home Phone: _____ Mobile: _____ Other: _____

Home Address: _____ City/St/Zip: _____

Can Payment Be Made to Beneficiary at This Address? Yes/No

Make Benefit Check To: _____ Relationship to Injured: _____

Persons Authorized to Accept Payment on Behalf Or In Addition To Injured:

_____

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 Address: _____

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: _____