KENTUCKY PUBLIC PENSIONS AUTHORITY
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Print Form

Form 6800
Revised 06/2023

Application for Duty Related/In Line of Duty Survivor Benefits

Deceased Member Information

Member Name:		Member ID:	
Birthdate:	Marital Status: ☐ Married ☐ Single ☐ Divorced		
Date of Death:	Termination Date (if different than date of death):		

Employer Information

Agency Name:	Telephone:	Fax:	
Agency Address:	City:	State:	Zip Code:

Incident Information
Please provide the requested information below and submit the following documents with this form:

(1) Member's death certificate (2) Incident investigation report (3) Police report (if applicable) (4) Employee's job description

Date of Incident:	Time of Incident:

Location of Incident:

Is there a police report documenting this incident? ☐ Yes ☐ No If yes, please submit a copy with this form.

Description of Incident:

Certification

I hereby certify that the information completed on this form is true and accurate. I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, the employer I represent, and I (personally) may be liable for restitution of the death benefits the spouse, child, dependent, or beneficiary was not eligible to receive, civil payments, legal fees, and costs.

Printed Name of Member's Immediate Supervisor: _____

Signature of Member's Immediate Supervisor: _____ Date: _____

Approved by:

Printed Name of Agency Head: _____

Signature of Agency Head: _____ Date: _____