LAW ENFORCEMENT OFFICERS AND FIRE FIGHTERS DEATH BENEFITS TRUST

BENEFICIARY DESIGNATION FORM

FOR:

DEATH BENEFITS OF COVERED PUBLIC EMPLOYEES KILLED IN THE LINE OF DUTY, PURSUANT TO MCA § 45-2-1, AS AMENDED.

Pursuant to the provisions of Mississippi Code Annotated Section 45-2-1, as amended by Chapter 429, Senate Bill 2688, Mississippi Legislature, 2007 Regular Session, effective August 1, 2006, **I acknowledge and understand that** the Mississippi Department of Public Safety is responsible for management of the trust fund and disbursement of the $65,000 death benefit authorized under the statute when a covered individual, while engaged in the performance of the person's official duties, is accidentally or intentionally killed or receives accidental or intentional bodily injury that results in the loss of the covered individual's life, provided that the killing is not the result of suicide and that the bodily injury is not intentionally self-inflicted.

According to the amended statute, the death benefit payment shall be made to the beneficiary who was designated in writing by the covered individual, as signed by the covered individual and delivered to the employer during the covered individual's lifetime. If no such designation is made, then the payment shall be made to the surviving child or children and spouse in equal portions, and if there is no surviving child or spouse, then to the individual's parent or parents. If a beneficiary is not designated and there is no surviving child, spouse or parent, then the payment shall be made to the covered individual's estate.

The death benefit payment is in addition to any workers' compensation or pension benefits and is exempt from the claims and demands of creditors of the covered individual.

For purpose of compliance with the statute, the following information identifies me and accordingly, designates my beneficiaries:

NAME OF COVERED INDIVIDUAL:

_____	_____	_____
First	Middle	Last

SOCIAL SECURITY NUMBER: DATE OF BIRTH:

_____ _____

DESIGNATED BENEFICIARY (BENEFICIARIES):

BENEFICIARY NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	RELATIONSHIP:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This signed document designates the above named person(s) as my beneficiaries for purpose of receiving MCA § 45-2-1 death benefits:

_____ COVERED INDIVIDUAL'S SIGNATURE _____ DATE OF SIGNATURE

A C K N O W L E D G M E N T

STATE OF MISSISSIPPI
COUNTY OF _____

PERSONALLY APPEARED BEFORE ME, the undersigned authority in and for the said county and state, on this _____ day of _____, 20____, within my jurisdiction, the within named _____, who acknowledged that they executed and delivered the above and foregoing instrument for the purposes contained therein.

In witness whereof, I hereunto set my hand and official seal.

_____
Notary Public

SEAL

My Commission Expires:_____

FORM PREPARED UPON REQUEST:
R. STEVEN COLEMAN, ATTORNEY, SR.
MISSISSIPPI BAR # 6365

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