CD-1033-0122

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS - BENEFICIARY SERVICES

P.O. Box 295, Trenton, NJ 08625-0295

EMPLOYER CERTIFICATION: DEATH CLAIM FOR DCRP MEMBERS

Name of Deceased _____

Membership Number _____ Social Security Number _____

Date Employed _____/_____/_____ Last Day of Active Service _____/_____/_____ Date of Death _____/_____/_____

ITEM 1

Did the member die within their first year of active service? ☐ No ☐ Yes

Was death due to an accident in the course of employment? ☐ No ☐ Yes

Was member on an official leave of absence with or without pay? ☐ No ☐ Yes — If yes, you must give date granted, reason, and support documentation.

☐ Leave of Absence With Pay _____/_____/_____ (*From*) _____/_____/_____ (*To*)

☐ Leave of Absence Without Pay _____/_____/_____ (*From*) _____/_____/_____ (*To*)

☐ Other _____/_____/_____ (*From*) _____/_____/_____ (*To*)

Reason For Leave _____

If the member was on a leave of absence without pay, please attach leave of absence documentation such as: a resolution, board minutes, PMMS records, FMLA papers, Disability/Workers' Compensation documents, etc. This information is required for all members who were on a leave of absence at the time of their death to ensure their heirs receive group life insurance. All documentation dated after the member's date of death cannot be accepted.

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ITEM 2

Please provide the member's base salary information during the last 10/12 months of credible service prior to their date of death. For employees paid through the State Centralized Payroll Unit, please see the instructions on the back of this form.

	Month - Year	Base Salary Subject to Contributions This Quarter
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

ITEM 3

Annual salaries and effective dates of wages in last year of service (see instructions for example):

$ _____ ____/____/____ $ _____ ____/____/____ $ _____ ____/____/____
Salary *Date* *Salary* *Date* *Salary* *Date*

Were non-contributory insurance premiums paid by location? ☐ No ☐ Yes

_____ _____ _____/_____/_____
Print Certifying Officer Name *Signature of Certifying Officer* *Date*

_____ _____
Employing Agency/County *Phone Number*

THIS CLAIM CANNOT BE PROCESSED UNLESS ALL ITEMS ARE COMPLETED

INSTRUCTIONS

This form must be filed in all cases where a member of a State-administered retirement system dies while in active status with an employer.

It is necessary to answer all questions completely. This will avoid unnecessary correspondence and expedite the payment of the claim.

Item 1: This item must be completed in its entirety. Failure to do so will delay the processing of this claim.

Item 2: The “10/12 Month Period” certification should be identical to the “Quarterly Report of Contributions.” State agencies reporting deductions through the State Centralized Payroll Unit should send a screen print of the TREADHOC bi-weekly certification with this form in lieu of the “10/12 Month Period” certification on the front of this form.

Item 3: Example - Member dies January 2, 2021. During the last year of employment, the member had an annual salary of $26,000 effective September 1, 2020, $24,000 effective May 1, 2020, and $21,000 effective September 1, 2019. Item 10 would be completed as follows:

$26,000	9/1/20	$24,000	5/1/20	$21,000	9/1/19
Salary	Effective Date	Salary	Effective Date	Salary	Effective Date