EXHIBIT A

MS Attorney General's Office Use Only:	
Application #:	**Receipt Date:**
☐ **Approved** ☐ **Disapproved**	**Claim type:** ☐ **Law Enforcement Officer** ☐ **Fire Fighter**

STOP. Please read the fund policies and procedures prior to completing this application.

APPLICATION FOR BENEFITS
LAW ENFORCEMENT OFFICERS AND FIRE FIGHTERS DISABILITY BENEFITS TRUST FUND

Mail to: **MISSISSIPPI ATTORNEY GENERAL'S OFFICE**
c/o Law Enforcement Officers & Fire Fighters Disability Benefits Trust Fund
P.O. Box 220
Jackson, MS 39205-0220

A. APPLICANT INFORMATION To be completed and signed by the APPLICANT:

Applicant's Name: _____ SSN: _____

Date of Birth (mm/dd/yyyy): _____ Gender: ☐ Male ☐ Female

Street Address: _____
Street (Apt. #) City State Zip Code

Mailing Address: _____
City State Zip Code

Home Phone Number: _____ Cell/Other Number: _____

Email Address: _____

Employer Name and Address: _____

_____

Date of Injury: _____/_____/_____ Time of Injury: _____am / pm (circle one)

Tell us how your injury occurred: _____

_____

_____

_____

_____

_____

_____

APPLICANT NAME _____ **SSN** _____

A. APPLICANT INFORMATION (continued) To be completed and signed by the APPLICANT:

Were you acting in the line of duty at the time of the incident? ☐ Yes ☐ No

Have you previously had the same/similar injury? _____If so, when? _____

Have you filed, or do you plan to file, for Workers' Compensation? ☐ Yes ☐ No

Physician/Healthcare Provider Information:

Physician Name: _____

Mailing Address: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of this application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.

_____ _____

Applicant's Signature **Date (mm/dd/yyyy)**

If applicable, I signed on behalf of the applicant as legal representative. (Please attach a copy of documentation authorizing legal representation.)

_____ _____ _____

Printed name of legal representative **Signature of legal representative** **Date (mm/dd/yyyy)**

****When completing the W-9 (page 8 of this application), include applicant name, address and SSN. Also, please remember to sign and date form.**

APPLICANT NAME _____ **SSN** _____

B. PHYSICIAN'S CERTIFICATION To be completed and signed by the PHYSICIAN treating you for this disability:

Diagnosis/primary disabling condition: _____

Has this patient been treated for the same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment: _____

_____

Is this patient temporarily disabled? ☐ Yes ☐ No
If yes, what are the temporary restrictions/limitations? _____

Anticipated return to work/release date: _____ If undetermined, based on your medical knowledge, what is a reasonable time frame before you expect to be able to release this patient to return to work? _____

Dates unable to work: From ____/____/____ To: ____/____/____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the patient's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.

Signature of physician: _____ **Date (mm/dd/yyyy)** _____

Name of physician: _____ Phone: (____) _____

Fax: (____) _____ **Tax ID or SSN:** _____

Address: _____

Email address: _____ **Patient #:** _____

NOTE: Please make a copy of the patient's signed Authorization for Release of Records (Section D) for your records.

APPLICANT NAME _____ **SSN** _____

C. EMPLOYMENT INFORMATION To be completed and signed by your EMPLOYER.

Name of Employer: _____ Phone Number (____)_____

Mailing Address: _____

Email Address: _____ Fax Number: (____)_____

Employee's Job Title: _____

For the purposes of determining eligibility for benefits, Section 45-2-21, Mississippi Code Annotated (1972) sets forth the following definitions:

"Fire fighter" means an individual who is trained for the prevention and control of the loss of life and property from fire or other emergencies, who is assigned to firefighting activity, and is required to respond to alarms and perform emergency actions at the location of a fire, hazardous materials or other emergency incident.

"Law enforcement officer" means any lawfully sworn officer or employee of the state or any political subdivision of the state whose duties require the officer or employee to investigate, pursue, apprehend, arrest, transport or maintain custody of persons who are charged with, suspected of committing, or convicted of a crime.

This employee ☐ does ☐ does not (check one) meet the criteria of one of the above definitions. Please attach a copy of the employee's Professional Certificate as being qualified to be a Mississippi Law Enforcement Officer or Fire Fighter to this application. For Fire Fighters employed prior to 1991, please provide proof of employment prior to 1991.

Average hours per week the employee worked prior to this incident: _____ hours/week

Monthly Salary $ _____ Annual Salary $ _____

Regular Base Salary: _____

Benefits under this program are calculated using regular base salary only.

Last work date: _____

Has the employee returned to work? ☐ Yes ☐ No Date employee returned to work: _____

APPLICANT NAME _____ **SSN** _____

C. EMPLOYMENT INFORMATION (continued) To be completed and signed by your EMPLOYER.

Has Workers' Compensation been applied for? ☐ Yes ☐ No Approved? ☐ Yes ☐ No

Name, address and phone number of Workers' Compensation carrier: _____

_____

Is this condition the result of an accidental or intentional injury received in the line of duty as the result of a single incident? ☐ Yes ☐ No

If yes, please provide the date and description of the incident: _____

_____

_____

_____

_____

_____

_____

_____

_____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the employee's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information. ***Furthermore, I will notify the Mississippi Attorney General's Office in writing the exact date the employee returns to work. This notification shall be submitted no later than ten days after the employee returns to work in the format prescribed by the Mississippi Attorney General's Office.***

_____ _____ _____

Employer Representative Name (Please Print or Type) **Job Title** **Date (mm/dd/yyyy)**

_____

Employer Signature

NOTE: Please make a copy of the employee's signed Authorization for Release of Records (Section D) for your records.

APPLICANT NAME _____ **SSN** _____

D. AUTHORIZATION FOR RELEASE OF RECORD To be completed by APPLICANT

For the purpose of evaluating my eligibility for benefits including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application, I hereby authorize the disclosure of information from my physician/healthcare provider and from my employer to the Mississippi Attorney General's Office or its authorized representatives.

Health information may be disclosed by any physician or healthcare provider that has any records or knowledge about the incident referred to on this application. Non health information including earnings or employment history or any other facts deemed appropriate by the Mississippi Attorney General's Office or its authorized representatives to evaluate my application may be disclosed by any entity, person, or organization that has records about me, including but not limited to my employer, employer representative and compensation sources.

Any information the Mississippi Attorney General's Office or its authorized representatives obtain pursuant to this authorization will be used only for the purpose of evaluating and administering my application for benefits. The Mississippi Attorney General's Office or its authorized representatives will not disclose any information unless permitted by federal and/or state laws. I further authorize the Mississippi Attorney General's Office to notify my employer of any benefits received and any employer responsibilities as related to my claim.

This authorization is valid for two (2) years from its execution, and a copy is as valid as the original. I know that I may request a copy of this authorization to request this information. This authorization may be revoked by me at any time except to the extent the Mississippi Attorney General's Office or its authorized representatives has relied on the authorization prior to notice of revocation. If revoked, the Mississippi Attorney General's Office or its authorized representatives may not be able to evaluate my application for benefits. I may revoke this authorization by sending written notice to: Mississippi Attorney General's Office, c/o Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund, P. O. Box 220, Jackson, MS 39205.

You may refuse to sign this form; however, the Mississippi Attorney General's Office or its authorized representatives will not be able to evaluate your application or administer your claim for benefits. I am the individual to whom this authorization applies or that person's legal representative.

_____ _____

Printed name of individual subject to this disclosure **Social Security Number**

_____ _____

Signature **Date (mm/dd/yyyy)**

If applicable, I signed on behalf of the applicant as legal representative. (Please attach a copy of documentation authorizing legal representation.)

_____ _____ _____

Printed name of legal representative **Signature of legal representative** **Date (mm/dd/yyyy)**

_____ _____ _____

Printed name of witness **Printed name of witness** **Date (mm/dd/yyyy)**

STATE OF MISSISSIPPI VENDOR REGISTRATION FORM

NAME OF APPLICANT:			
SSN NUMBER:			
MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS)			
STREET ADDRESS:			
CITY:		STATE:	ZIP:
PHYSICAL ADDRESS			
STREET ADDRESS:			
CITY:		STATE:	ZIP:
PHONE NUMBER:	FAX NUMBER:		
EMAIL ADDRESS:			
FOR OFFICE USE ONLY			
COMMENTS:			
RECEIVED BY:	COMPLETED BY:		
RECEIVED DATE:	COMPLETED DATE:		

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

6 City, state, and ZIP code

Requester's name and address (optional)

MISSISSIPPI ATTORNEY GENERAL'S OFFICE
c/o Law Enforcement Officers & Fire Fighters Disability Benefits Trust Fund P.O. Box 220
Jackson, MS 39205-0220

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*