EXHIBIT D

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 7 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 doctor: _____ **Date (mm/dd/yyyy)** _____

Name of doctor: _____ 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 **VOLUNTEER** EMPLOYER.

Name of **Volunteer** 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 Auxiliary/Reserve Law Enforcement Officer or Volunteer Fire Fighter to this application. Please provide copy of 911 Incident Report.

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

Last work date: _____

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

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

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

_____

_____

APPLICANT NAME _____ **SSN** _____

C. EMPLOYMENT INFORMATION (cont). To be completed and signed by your **VOLUNTEER** EMPLOYER.

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

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

Name of **Primary** Employer: _____ Phone Number (____)_____

Mailing Address: _____

Email Address: _____ Fax Number: (____)_____

Employee's Job Title: _____

APPLICANT NAME _____ **SSN** _____

C. EMPLOYMENT INFORMATION (cont.). To be completed and signed by your **PRIMARY** EMPLOYER.

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

Last work date: _____

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

Monthly salary $ _____ Annual Salary $ _____

For the last full pay period worked prior to injury, please include the following information:

Pay Period (mm/dd/yyyy): From _____/_____/_____ To _____/_____/_____

Base Wages: _____ Overtime Wages: _____

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 RECORDS. 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)**

STATE OF MISSISSIPPI

COUNTY OF

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named_____, who acknowledged to me that he signed and delivered the above forgoing waiver on the date therein mentioned and for the purpose therein expressed.

Given under my hand and seal of office, this_____ day of_____, _____.

_____ **NOTARY PUBLIC**

STATE OF MISSISSIPPI VENDOR REGISTRATION FORM

NAME OF APPLICANT:		
SSN NUMBER:		
MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS)		
STREET ADDRESS:		PO BOX:
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. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 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. person (including a U.S. resident alien).

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 on page 4.)

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

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,