Healthcare Financial Assistance Application

This application is for survivors of Law Enforcement Officers killed in the line of duty who were covered under your spouse's/parent's policy at the time of their death and have not aged out. If you need help to complete this form please email us at healthcare@iowacops.org.

We want applicants to know that there may be additional funding sources available to them. The following are sources that may be available to you: Your employer's group insurance, private insurance, other insurance (ie Allstate, AFLAC), employer reimbursements for deductibles or health care expenses, state assistance (crime victims), National COPS Counseling assistance, COBRA, Medicare or Medicaid.

Instructions for completing this form:
Please fill this form out completely and return all required documentation to the Iowa Concerns of Police Survivors Healthcare Committee via mail or email:
MAIL: Iowa C.O.P.S. Attn: Healthcare Committee PO BOX 52 Granger, IA 50109
EMAIL: healthcare@iowacops.org
Financial assistance will not be considered to those who do not complete the application process in full. Applying does not imply reimbursement. Please submit the following documentation:

1. Proof of insurance cost and any health care bills you are looking to be reimbursed for in verification noted below.
2. Letter from the Department your officer was employed by stating coverage benefits at time of death, and current benefits offered to you and your dependents.
3. If filing for an adult dependent of the officer (between age 18-26), proof of payment and statement from them as to who should be reimbursed.

Quarterly Due Dates: February 1st, May 1st, August 1st, November 1st.

Applications will be reviewed quarterly. We will consider claims for dates of service prior to the 1st day of February, May, August and November that have not yet been submitted. On the sheet provided please itemize your outstanding medical expenses (IE Deductible, co-insurance, etc). Please add an additional sheet if you feel there is additional information. Proof of payment is required and additional verification may be required.

Checklist of all required information to complete application process:

- Form filled out completely with signature and date
- Letter from Department (only needed the 1st time you submit)
- Proof of expense and payment

Please complete page two and return the completed application to IOWA C.O.P.S.

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Officer Information:

Officer's Name _____ Officer DOB _____ Officer EOW _____

Department Officer was employed by _____

PSOB (Public Safety Officer Benefit) Application Status _____ (Approved, denied, In progress, or not submitted)

Survivor Information:

Primary Survivor Name _____ Birth Date _____

Relationship to Officer _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Additional Dependents:

List additional dependents that officer carried insurance for whom you are seeking expense reimbursement.

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

Name _____ Relationship _____ DOB _____

Please specifically list what you are requesting below, applying does not imply reimbursement:

Date	Amount	Expense Description

Total reimbursement Requested: _____

I hereby state that the information given herein is true and correct. I authorize any required verification or medical releases. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered.

Responsible Party Signature_____ Date _____