NEBRASKA

DEPT. OF ADMINISTRATIVE SERVICES

Standard Operating Procedures:

How to File a Line of Duty Compensation Act Claim With the State of Nebraska

Department of Administrative Services

Risk Management

Created By:	Angela Sears
Approved By:	Allen Simpson
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State Line of Duty Claims

Line of Duty claims shall mean any claim against the State for a “First Responder” who dies in the line of duty.

Typical Miscellaneous Claims would be for:

- A Nebraska fire fighter who dies fighting a fire.
- A Nebraska Correctional worker who dies in a prison riot.
- A Nebraska Police officer who dies while trying to make an arrest or in a high-speed chase.

All such claims and supporting documents shall be filed with the Office of Risk Management. It is important to keep copies of all documents submitted as the Office of Risk Management does not return any documents to the Claimant.

All claims permitted under LB225 shall be forever barred unless the claim is filed with Risk Management within one years after the date of death of the public safety officer.

TO FILE A LINE OF DUTY CLAIM:

Download the Line of Duty Claim Form from the Risk Management Website.
Only fully completed and signed Line of Duty Claim Forms will be accepted by the Office of Risk Management.

State of Nebraska Line of Duty Compensation Act Claim Form

This form is for Line of Duty Compensation Act Claims (Nebraska Statue 81-8,315 to 81-8,319).

Only **COMPLETED** and **SIGNED** Claim Forms will be accepted by the Office of Risk Management.

FOR OFFICE USE ONLY

* Indicates a **REQUIRED** field. If required fields are not filled out, your Claim will not be processed.

Claimant's Name*:	Claimant's Phone Number*:	Alternate Phone Number:
Name of Person Who Died in Line of Duty*:	Title of person who died*:	Manager's Name*:
Manager's Phone Number*:	Manager's Address:	Manager's City/State:
Claimant's Mailing Address*:	Claimant's Email Address:	Is Claimant Named Beneficiary? ☐ YES ☐ NO
Did the First Responder die in the Line of Duty*? ☐ YES ☐ NO	Is Claimant a State Employee? ☐ YES ☐ NO	If YES, What State Agency?
Date of Occurrence*:	Place of Occurrence*:	City of Occurrence*:

In the below space, please provide a detailed itemization of all known facts/circumstances leading to your claim. Identify all property, places, and people involved. Include names, addresses, and phone numbers of witnesses, if any. The information provided below, along with the findings of the investigating agency, will form the basis of any decision.

If additional space is needed, please use another page.

Claimant Signature*:	Date*:

Under Penalties of law, I declare that I have examined this statement and that it is, to the best of my knowledge and belief, true, complete, and correct, and that I am duly authorized to sign this statement.

Please include copies of any supporting documents that may be relevant to your claim including, but not limited to, Police Reports, Estimates, Copy of Autopsy and / or Death Certificates, etc.

Make and keep copies of all documentation submitted as copies will not be provided.

Claim form and supporting documents should be emailed to: az.riskmanagement@nebraska.gov
If you are unable to submit your claim by email, you may mail your claim to: Office of Risk Management, PO Box 94974, Lincoln, NE 68509-4974 Questions? Call the Office of Risk Management at (402) 471-2551

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The following pages explain the various sections of the Line of Duty Claim Form. The title of each section is provided, followed by a description and an explanation of the information requested. Please note that when a field contains an asterisk (*), it is a **REQUIRED FIELD** and cannot be left blank. Please fill out the fields with the asterisks completely. This will help the investigation.

Claimant's Name*:
This is the name of the person making the claim. If the claim were to be approved, this is also the person who will be paid, unless the deceased has named a different beneficiary. This name is the same as the Claimant's signature.

Claimant's Phone Number *:
This is the phone number of the Claimant, the number where the Claimant can be reached during the day.

Alternate Phone Number:
This is any other phone number than the daytime phone number listed above. This field may be left blank when there is no alternate phone number.

Name of the Person Who Died in the Line of Duty*:
This should be the full legal name of the person who died in the line of duty.

Title of the Person Who Died*:
This should be the title of the person who died in the line of duty. (ex. Firefighter, Detective, etc)

Manager's Name*:
This should be the full legal name of the person who managed the person who died in the line of duty.

Manager's Phone Number*:
This should be the telephone number of the person who managed the person who died in the line of duty.

Manager's Address:
This is the mailing address of the person who managed the person who died in the line of duty.

Manager's City and State:
This should be the city/state of the person who managed the person who died in the line of duty.

Claimant's Mailing Address*:
This is the current mailing address of the Claimant.

Claimant's Email Address:
Does the Claimant have an email address? If so, please list the email address here. This is not a required field. This space may be left blank if there is no email address.

Is Claimant Named Beneficiary?
If the Claimant does not know if they are the named beneficiary, they should check no and file the clam anyway. This will be sorted out during the investigation.

Did the First Responder Die in the Line of Duty?*:
If so, select YES. If not, select NO.

Is Claimant a State Employee?:
Is/was the Claimant employed by the State of Nebraska? If so, select YES. If the Claimant is/was not an employee of the State of Nebraska, select NO.

If Yes, What State Agency?:
If the Claimant is/was an employee of the State of Nebraska and this claim is work-related, in what State agency is/was the Claimant employed?

Date of Occurrence *:
This is the date that the incident listed on the claim occurred. When did the loss occur? When did the incident happen?

Place of Occurrence *:
Where exactly did this incident occur?

City of Occurrence *:
In what Nebraska city/town did this incident occur? If the incident occurred in the country what was the nearest city/town?

Itemization of All Known Facts/Circumstances Leading to Your Claim *:
In the space provided, please list a detailed summary of all known facts or circumstances leading to this claim. Identify all property, places and people involved. Include names, addresses and phone numbers of witnesses, if any. Attach additional documents, if needed, to complete this field. This is an important field that describes in detail the circumstances of the event that led to the claim. This information will help the investigation. The information provided, along with the findings of the investigation, will form the basis of any decision.

Claimant Signature*:
We need the Claimant's signature as we are unable to process the claim without it.

Date*:
This is the date that the Claimant is signing the form. Claims cannot be processed without it.

Note: Only completed and signed Claim Forms will be accepted. Please retain copies of all enclosed documents, including this claim form.

Claimant must provide the necessary documentation to substantiate their claim. Examples of documents to submit could include, but are not limited to; police reports, death certificates, autopsy results, newspaper articles etc. Do not send originals; **send copies only**. This information will help the investigation of the claim.

Once the Claim Form has been completed please submit to the Office of Risk Management. It is recommended that the form be submitted electronically, however it can also be submitted by mail or in-person.

To Submit Your Claim Electronically:

Please email the completed, signed and dated form as well as any supporting documents to: as.riskmanagement@nebraska.gov

If submitting electronically, keep in mind that a typed signature is legally binding and equivalent to a handwritten signature.

To Submit Your Claim by Mail:

Please mail the completed, signed and dated form with any supporting documents to:

Office of Risk Management
PO Box 94974
Lincoln, NE 68509-4974

To Submit Your Claim in Person:

Please bring the completed, signed, and dated form as well as any supporting documents to:

Office of Risk Management
1526 K Street, Suite 180
Lincoln, NE 68508

What Happens Next?

Claims recommended for approval by the Risk Manager will then need to be approved by the State Claims Board and the Nebraska State Legislature. The Legislature meets once per year, beginning in January. If approved by the Nebraska State Legislature, the signature of the Governor of Nebraska is required to process the claim for payment. This entire process could take up to a year depending on when the claim comes in so please be patient with us.

State Claims Board Hearings:

The Director of Insurance, Commissioner of Labor, and Director of Administrative Services shall constitute the State Claims Board which shall be part of the Risk Management Program created by section Nebraska Revised Statute § 81-8,239.01. The Attorney General shall be its legal advisor. (See Nebraska Revised Statute § 81-8,220)

The State Claims Board generally meets quarterly however does occasionally schedule extra meetings if needed to process claims in a timely manner. The dates of the hearings are posted under the State Claims Board tab at the Office of Risk Management website. The hearings are informal pursuant to the Open Meetings Act, Nebraska Revised Statutes §§ 84-1407 to 84-1414. The Claimant does not need to be present for the claim to be heard. Claims will be heard before the Nebraska Legislature once per year.

Please call the Office of Risk Management at (402) 471-2551, Monday – Friday, 8 AM to 5 PM, if there are any questions.

It is important to keep copies of all documentation submitted to the Office of Risk Management, State of Nebraska.