



CHICAGO BENEFITS OFFICE  
2 N. LaSalle Street, Room 1240  
Chicago, Illinois 60602-4045

**Application For  
Public Safety Employee Benefits under the Illinois Public Safety Employee Benefits Act,  
820 ILCS 320/10**

As required by the Illinois Public Safety Employee Benefits Act, 820 ILCS 320/10 (“PSEBA”), the City of Chicago pays the premium of its basic group health insurance plan for certain police officers and firefighters, their spouses and dependent children. To be eligible for this PSEBA benefit, you must qualify under one of the following categories:

1. You are a police officer catastrophically injured during response to fresh pursuit, or you are a police officer or firefighter\* catastrophically injured in response to what was reasonably believed to be an emergency, to an unlawful act perpetrated by another, or during the investigation of a criminal act.
2. You are the spouse of a police officer catastrophically injured during response to fresh pursuit, or you are a police officer or firefighter\* catastrophically injured in response to what was reasonably believed to be an emergency, to an unlawful act perpetrated by another, or during the investigation of a criminal act.
3. You are the child of a police officer catastrophically injured during response to fresh pursuit, or you are a police officer or firefighter\* catastrophically injured in response to what was reasonably believed to be an emergency, to an unlawful act perpetrated by another, or during the investigation of a criminal act. and:
  - you are under 18 years old or
  - you are 18-25 years old, and you are a full-time or part-time student dependent for support, or
  - you are 18-25 and dependent for support.

The PSEBA benefit does not change other benefits for which injured police officers and firefighters and their families may be eligible under applicable collective bargaining agreements.

If you believe you are eligible for the PSEBA benefit, complete the attached PSEBA Application Form, beginning on page 2 below, and the Authorization Form for the Use and Disclosure of Protected Health Information and mail both forms to:

CHICAGO BENEFITS OFFICE  
2 N. LaSalle Street, Suite 1240  
Chicago, Illinois 60602-4045

*\*Includes paramedic/EMT*



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**PSEBA APPLICATION FORM**

1. Applicant's Name: \_\_\_\_\_
2. Applicant's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (or TIN if no SSN)
3. Name of Injured/Deceased Public Safety Employee \_\_\_\_\_
4. Injured/Deceased Public Safety Employee's Employee ID Number: \_\_\_\_\_
5. Applicant's Mailing Address:  
\_\_\_\_\_  
\_\_\_\_\_
6. Applicant's Preferred Email address: \_\_\_\_\_
7. Applicant's Telephone:  
(Home/Cell): \_\_\_\_\_ (Work): \_\_\_\_\_
8. Applicant's birth date: \_\_\_\_\_
9. Birth date of Public Safety Employee: \_\_\_\_\_
10. Public Safety Officer is: (check one box):
  - ☐ Police Officer
  - ☐ Firefighter
  - ☐ Firefighter/paramedic/EMT
11. Applicant's relationship to the Public Safety Employee (check one box):
  - ☐ Self
  - ☐ Currently married to Public Safety Employee
  - ☐ Surviving spouse, not remarried
  - ☐ Child under 18
  - ☐ Child 18-25 dependent for support
  - ☐ Child 18-25 and full-time or part-time student\* and dependent for support.

*\*Attach a copy of current class schedule as proof of your status as a student*



12. Date of Public Safety Employee's injury and/or death: \_\_\_\_\_

13. Location or address of Public Safety Employee's injury and/or death:

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14. Description of how injury and/or death occurred (you may attach any official reports or other documentation of the circumstances of the injury and/or death)

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15. Have you made any other requests for PSEBA benefits?

- ☐ No
- ☐ Yes (If yes, provide the date where the application was made, and reason application was made. Attach copy of application, if available.)

16. Has the Public Safety Employee applied for a line-of-duty-disability pension from the Firemen's Annuity & Benefit Fund of Chicago or from the Policemen's Annuity & Benefit Fund?

- ☐ No
- ☐ Yes (attach copy of application)

17. Has the Firemen's Annuity & Benefit Fund of Chicago or the Policemen's Annuity & Benefit Fund granted the Public Safety Employee a line-of-duty disability pension?

- ☐ No (attach copy of denial, if any)
- ☐ Yes (attach copy of determination letter)

18. List any other health insurance plans under which you, the Applicant, are covered. Include the name of the insurance company or employer, and benefit plan.

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19. List any other health insurance plans under which you, the Applicant, are eligible, (even though you may not have enrolled, or have not been enrolled by another person such as



by your spouse). Include the name of the insurance company or employer, and benefit plan.

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20. Are you, the Applicant, eligible for Medicare? If you are eligible you must answer “yes” even if you have not elected or obtained Medicare coverage.

- ☐ Yes
- ☐ No

21. If you answered “No” to the Medicare question above, but are age 65 or older, do you have a letter from Medicare denying you coverage under that program?

- ☐ Yes (Submit a copy of the letter)
- ☐ No (Contact Medicare to obtain that letter. Your application is not complete until you provide the letter)



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**I, the undersigned, the Applicant for the PSEBA benefit, state as follows:**

**I believe I may be eligible for benefits under the Public Safety Employee Benefits Act, 820 ILC S 320/10, and submit the above information in support of my application.**

**I understand that to determine eligibility for these benefits, the City of Chicago may need to review relevant employment and pension records for the injured or deceased Public Safety Employee. I hereby authorize the City of Chicago to review records from the Chicago Police Department and/or the Chicago Fire Department and/or the Firemen's Annuity & Benefit Fund of Chicago and/or Policemen's Annuity & Benefit Fund of Chicago.**

**I understand that to determine eligibility for these benefits, the City of Chicago may need to review relevant medical records for myself and/or the injured or deceased Public Safety Officer. I have completed and signed the attached Authorization Form for the Use and Disclosure of Protected Health Information authorizing the City of Chicago to review these records.**

**I understand that while my application is being considered and at any time I am receiving benefits under the Public Safety Employees Benefits Act I must obtain Medicare coverage when I become eligible (whether through my own employment earnings, a spouse's employment earnings and/or an ex-spouse's employment earnings).**

**I understand and agree that ANY individual obtaining benefits under the Public Safety Employee Benefit Act is obligated to inform the Chicago Benefits Office, 2 N. LaSalle St, Room 1240, Illinois 60602 while my application is being considered and at any time I am receiving benefits under the Public Safety Employees Benefits Act if:**

- **I am the spouse of a deceased Public Safety Officer and I remarry.**
- **I am 18-25 and no longer dependent for support or I am no longer a full-time or part-time student.**
- **I am eligible for other health insurance and/or I obtain other health insurance, including Medicare.**

**I understand and agree that any claimant (spouse, dependent, or myself) is obligated to inform the Chicago Benefits Office if the Public Safety Officer or any other claimant (spouse, dependent):**

- **Obtains other health insurance**
- **Becomes eligible to obtain other health insurance**
- **Obtains Medicare for any reason (e.g. age, disability or end stage renal disease)**
- **Becomes eligible for Medicare for any reason (e.g. age, disability or end stage renal disease)**

**I understand and agree that any claimant's benefits automatically will end upon Medicare eligibility age (the first of the month in which the claimant attains age 65) unless the**



claimant submits a letter from Medicare demonstrating that Medicare eligibility is not available.

**I understand that it is unlawful for a person to willfully and knowingly make or cause to be made, or to assist, conspire with, or urge another to make or cause to be made, any false, fraudulent, or misleading oral or written statement to obtain health insurance coverage as provided by the Public Safety Employee Benefits Act, and that such unlawful act will result in forfeiture of the right to receive health insurance benefits and obligate the person to reimburse the City of Chicago for all benefits paid due to the fraud or other prohibited activity, as provided in 820 ILCS 320/10(a)(3). I understand that such unlawful act constitutes a Class A misdemeanor and can serve as the basis for denial of future benefits. Further I understand that any omission or misstatement related to this application can result in a basis for denial of benefits under the Public Safety Employee Benefits Act.**

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Signature of Applicant

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Date

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Printed Name of Applicant

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Printed Name of Personal Representative (if applicable)

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Relationship to Applicant (if applicable)