

**CHARLES COUNTY LENGTH OF SERVICE AWARD PROGRAM (LOSAP)
PAYMENT AUTHORIZATION FORM**

NAME OF VOLUNTEER'S DEPARTMENT: _____

Name of Participant: _____
(Last) (First) (M.I.)

Participant's Date Birth (MM/DD/YYYY): _____

Participant's Social Security Number: _____

Participant's Residence Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Participant's Phone Number: _____

Name of Participant's Spouse: _____
(Last) (First) (M.I.)

Spouse's Date of Birth (MM/DD/YYYY): _____

Spouse's Social Security Number: _____

Spouse's Residence Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Benefits are to Begin: _____

Benefits under Article II, Section 54-9 through 54-11;

1. _____ **(B)** Minimum age 60 and a minimum of 25 years certified volunteer service
2. _____ **(C)** _____ Additional years certified volunteer service
3. _____ **(D) & (E)** Copy of proof of disability attached; _____ years of certified volunteer service
4. _____ **(F) & (G)** Survivor Benefit (Spouse's information above); _____ years of certified volunteer service
(An original death certificate including seal must be attached to this form)
5. _____ **(H)** Death Benefit - qualified (Spouse's information above or Estate of Participant named above) - \$5,000
(An original death certificate including seal must be attached to this form)
6. _____ **(I)** Age of 70; _____ years of certified volunteer service (must have 2 qualified years within the last 5)
7. _____ **(J)** Death Benefit - unqualified (Spouse's information above or Estate of Participant named above) - \$5,000
(An original death certificate including seal must be attached to this form)
8. _____ **(L)** Early Receipt of Benefits; minimum age 55 and a minimum of 25 years certified volunteer service
9. _____ **(L)** _____ Additional years certified volunteer service

**I am requesting participation in the Charles County LOSAP and understand the qualifications
and requirements to participate in this program.**

Participant's Signature: _____ **Date:** _____

**We have reviewed the LOSAP records of the above participant and believe the requirements
have been met for the benefits as checked:**

LOSAP Coordinator's Signature: _____ **Date:** _____

Signatures of the Board of Director's of the Department indicate certification of the above information:

(Signature)	(Print Name)	(Title)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____