SEATTLE FIREFIGHTERS PENSION BOARD
2200 6TH AVENUE STE #820
SEATTLE WA 98121-1822

FIREFIGHTERS STATEMENT
OF OTHER HEALTH/MEDICAL BENEFITS (LEOFF 1)
ALL QUESTIONS MUST BE ANSWERED

Name ____ Social Security Number
Last First Middle Initial

Address ____ _________-_____-__________

____ Active: CPO ______________
City State Zip + 4

Phone ( ) __________________ Birth Date _______/_____/ _______ Retired: Mo______Year______

Your Wife's Social Security # _________ - ______ - _________

RCW 41.26.150(2) states in part: "the medical services payable will be reduced by amount received or eligible to be received by the member under workman's compensation, social security including the changes incorporated under Public Law 89-97 as now or hereafter amended, insurance provided by another employer, or other pension plan or any similar source."

1. Are you eligible for Medicare? Yes _______ No________

2. Are you as an employee, currently eligible for Medical/Health benefits from an Employer other than the City of Seattle? If "Yes" complete the information on the back Yes _______ No ________

Effective Date _____________________ ______________________________________
MO YR Insurance Co.

3. If you are married, and your spouse is working, who is your spouse Employed by?

____
Employer

4. Are you eligible for coverage under your spouse's Medical/Health benefits? Yes ______ No ________
If "yes" complete the information on the back.
Effective Date: _____________________
MO YR

ANY EMPLOYER, MEMBER OR BENEFICIARY WHO KNOWINGLY MAKE FALSE OR SHALL FALSIFY OR PERMIT TO BE FALSIFIED ANY RECORD OR RECORDS OF THE RETIREMENT SYSTEM IN AN ATTEMPT TO DEFRAUD THE RETIREMENT SYSTEM, SHALL BE GUILTY OF A FELONY.

I certify that this information is correct and understand that falsification of the above information will cause denial of payment of any medical bills.

______________________________________ ______________________________________
Signature Date

RCW 41.26.150(2) requires members that have other insurance, or are eligible for other insurance through another employer, their spouse or any other insurance source, to submit all medical bills to the appropriate insurance as primary.

Note: Your Blue Cross coverage through the Pension Office is not considered other insurance.

Any member having other insurance as described shall complete the information below:

Other Insurance Company:

COMPANY NAME	
STREET ADDRESS	
CITY STATE ZIP CODE	
TELEPHONE NUMBER ( )	
NAME OF POLICY HOLDER	DATE OF BIRTH Month Day Year
POLICY ID # (Social Security # Member #, etc.)	RELATIONSHIP TO SUBSCRIBER
GROUP # (Cert. #, Union Local, etc)	
THIS COVERAGE IS FOR: **Medical______ Dental ______ Vision ________**	
ARE YOU RETIRED FROM THIS EMPLOYER? **Yes ________ No _________**	

Reminder: This coverage would be for the member only, not family members