WEST PALM BEACH ASSOCIATION OF FIREFIGHTERS
RETIREE HEALTH BENEFIT FUND
c/o Mierzwa & Floyd, P.A.
3900 Woodlake Blvd., Suite 212
Lake Worth, FL 33463

APPLICATION FOR BENEFITS & PARTICIPANT INFORMATION FORM

PLEASE CHECK ONE: **__ Initial Application for Benefits or __ Updated Participant Information**
(Initial Applications should be submitted at least 90 days before your retirement.)

PLEASE PRINT CLEARLY

Employee's Name: _____ SS#: _____ DOB: _____

Spouse's Name: _____ SS#: _____ DOB: _____

Date of Marriage: _____ Home Phone: _____

Mailing Address: _____ Cell Phone: _____

City, State, Zip: _____ E-Mail: _____

Please contact Thomas L. Sheppard, Administrative Manager, regarding any questions about the Fund or this form. Mr. Sheppard may be contacted by telephone at 561-373-0396 or by e-mail at smokeyffpm@aol.com.

PENSION INFORMATION:

Date of Retirement: _____ Date of Hire: _____

I am receiving a normal or disability retirement benefit from the City of West Palm Beach Firefighters' Pension Fund.

_____ Yes _____ No

CONTINUING HEALTH INSURANCE INFORMATION:

Retirees who elect to participate in the health insurance offered through the City of West Palm Beach will have their retiree benefit applied to the cost of monthly health insurance without having to submit proof of health insurance coverage. The Retiree Benefit Fund directly pays up to 100% of your retiree benefit toward the cost of health insurance. If the health insurance premium is more than your retiree benefit, you will have to pay the difference. If you do not elect to participate in the City's health insurance program, you are required to submit proof of payment of the health insurance premiums. All participants must submit proof of payment for other qualified expenses to be eligible for reimbursement by the Retiree Benefit Fund.

I will continue to participate in the City of West Palm Beach's health insurance plan and authorize the Retiree Benefit Fund to pay my Retiree Benefit Fund benefits directly toward the cost of such insurance. Yes_____ No _____

If No, you must provide a completed Statement and Proof of Incurred Expenses form to receive benefits from the Fund. Benefits are paid on a quarterly basis.

_____ _____
(Signature of Applicant) (Date)