SEATTLE POLICE PENSION FUND
Po Box 94729
Seattle, Washington 98124-4729
(206) 386-1287

RETIRED SEATTLE POLICE OFFICERS (LEOFF I ONLY)

STATEMENT OF OTHER HEALTH/MEDICAL BENEFITS - 2015

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____ PHONE _____

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

ALL QUESTIONS MUST BE ANSWERED COMPLETELY

Are you currently employed? ___ YES ___ NO Are you currently on Medicare A & B? ___ YES ___ NO

If employed, are you currently enrolled in a medical health plan from your employer? ___ YES ___ NO

NAME OF EMPLOYER _____Insurance Effective Date _____

EFFECTIVE DATE OF EMPLOYMENT _____ INSURANCE PLAN NAME _____

If your spouse is employed, are you currently enrolled under your spouse's benefits? ___YES ___ NO

IF YES, WHAT IS PLAN NAME? _____ EFFECTIVE DATE _____

******If enrolled through an employer or spouse's employer plan, please include a copy of your current card*******

ANY MEMBER OR BENEFICIARY WHO KNOWINGLY MAKES FALSE STATEMENTS 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 I UNDERSTAND THAT FALSIFICATION OF THE ABOVE INFORMATION COULD CAUSE DENIAL OF PAYMENT OF ANY MEDICAL BILLS.

SIGNATURE _____ **DATE** _____

********** NOTARY **********

SUBSCRIBED AND SWORN TO OR AFFIRMED BEFORE ME THIS _____ DAY OF _____, 20___.

NOTARY SIGNATURE _____

PRINTED _____

NOTARY PUBLIC IN AND FOR THE STATE _____

RESIDING AT_____