RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT TRUST

Administered By: Benefit Programs Administration Telephone: (562) 463-5050 Fax: (562) 463-5894 E-Mail: <u>smpoatrust@bpabenefits.com</u> <u>www.smpoatrust.org</u>

INFORMATION SHEET

[PLEASE PRINT]

Employee's Last Name	First Name				Initial		
Social Security No – –	Birthdate/						
Home Address				MO/DA	-,		
Telephone ()	E-mail						
BY PROVIDING YOUR E-MAIL ADDRESS, YOU CO OF INFORMATION AND ANNOUNCEMENTS RELA OFFICERS' ASSOCIATION BENEFIT TRUST. ADMINISTRATIVE OFFICE AT THE ADDRESS ABC	ATED TO THE RET YOU MAY RESCI	IREE M	MEDIC	AL PLAN OI	F THE SAN	NTA MONIC	A POLICE
Marital Status: () Single () Marrie	d () Divorce	ed	()	Domestic	Partners	hip	
Date of Marriage/Domestic Partnership							
Name of Spouse/Partner:							
Spouse/Partner's Social Security No.	_ — —		Birt		_/ D/DAY/YE/		
LIST	ELIGIBLE DEP	ENDI	ENTS		// DA 1/ 1 L/	-ik	
LAST NAME FIRST NAME	RELATIONSHIP	SEX		DA	DATE OF BIRTH		
		М	F	MO	DAY	YEAR	-
							-
							-
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							-
							-
EMERGENCY CONTACT:							4
Name:		Rela	tionsl	nip:			
Home Address:							
Telephone No. ()	Email Address:						
The above statements are true to the best of will disqualify me for benefits.	of my knowledge	e and	beliet	f. I under	stand tha	it a false s	tatement

FO/SM Police/Information Sheet

Your Signature

Date Signed