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: smpoatrust@bpabenefits.com www.smpoatrust.org

INFORMATION SHEET

[PLEASE PRINT]

Employee's Last Name First Name Initial

Social Security No. _____ – _____ – _____ Birthdate _____/_____/_____
MO/DAY/YEAR

Home Address_____

Telephone (____)_____ E-mail _____

BY PROVIDING YOUR E-MAIL ADDRESS, YOU CONSENT TO ITS USE TO PROVIDE ELECTRONIC NOTIFICATION TO YOU OF INFORMATION AND ANNOUNCEMENTS RELATED TO THE RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION BENEFIT TRUST. YOU MAY RESCIND THIS AUTHORIZATION BY CONTACTING THE ADMINISTRATIVE OFFICE AT THE ADDRESS ABOVE.

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Domestic Partnership

Date of Marriage/Domestic Partnership _____

Name of Spouse/Partner: _____

Spouse/Partner's Social Security No. _____ – ____ – _____ Birthdate _____/_____/____
MO/DAY/YEAR

LIST ELIGIBLE DEPENDENTS

LAST NAME FIRST NAME	RELATIONSHIP	SEX		DATE OF BIRTH		
		M	F	MO	DAY	YEAR

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Address: _____

Telephone No. (____) _____ Email Address: _____

The above statements are true to the best of my knowledge and belief. I understand that a false statement will disqualify me for benefits.

_____ _____
Your Signature Date Signed

1200 Wilshire Blvd. 5th Floor, Los Angeles, CA 90017-1906