



DEATH & DISABILITY BENEFITS ELIGIBILITY FORM

INSTRUCTIONS 1) Check one box below and complete the form. 2) Once completed, please send this form to FPPA at the address above.

- NEW MEMBER - Complete the *entire* form. **New employees must also complete the Statewide Standard Health History form.**
 CHANGES ONLY - Complete Part A below and any other information that you wish to change.

PART A - GENERAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Social Security # _____
 Address _____ Marital Status Single Married
 City _____ State _____ Zip _____ Date of Birth ____/____/____
Month Day Year
 (____) _____ (____) _____ Sex M F Email _____
Home Phone Number Work Phone Number

PART B - EMPLOYER

Name Department - City, Town or District _____ Check one Police Fire

Starting Date ____/____/____ Employed Full-time? Yes No Starting Gross Salary Per Month \$ _____
Month Day Year

Rank _____ Average Number of Hours Per Week _____

PART C - DEPENDENTS

Spouse's Name _____ Spouse's Date of Birth ____/____/____
Month Day Year

Please list below the names and birth dates of your unmarried children under the age of 23. Indicate whether children over 18 are full-time students. If necessary, list additional children on a separate sheet of paper and attach it to this form.

<u>Child's Name</u>	<u>Birth Date</u> (Month / Day / Year)	<u>Full Time Student</u>
_____	____/____/____	<input type="checkbox"/>
_____	____/____/____	<input type="checkbox"/>
_____	____/____/____	<input type="checkbox"/>

Check here if additional sheet is attached

PART D - EMPLOYMENT HISTORY

Have you ever worked as a firefighter or police officer with any other department in the State of Colorado? _____. If yes, please list below departments (cities/towns/ or special districts) where you worked, the dates of your employment and whether you were covered by Social Security for retirement benefits. Also indicate your position using the following service code: **P=Police, F=Paid Firefighter, V=Volunteer Firefighter.**

<u>Department Name</u>	<u>Employment Dates</u> (Month / Day / Year)	<u>SS Coverage</u>	<u>Service Code</u>
_____	From ____/____/____ To ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	From ____/____/____ To ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	From ____/____/____ To ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Have you ever received a refund of your pension contributions from any of the employers listed above? Yes No

If yes, indicate those employers _____

X _____ X _____
 Your Signature Witness to Your Signature Date
(someone other than your spouse)