CITY OF DETROIT POLICE & FIRE RETIREE HEALTHCARE TRUST

P.O. BOX 1198
TROY, MICHIGAN 48099-1198
(833) 725-5336

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____ Gender :(*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Telephone Number: (_____) _____ Alternate Phone Number: (_____) _____

Email Address: _____

Date of Retirement: _____

DEPENDENTS: Include Spouse (***Marriage/Birth Certificates are needed to add any dependents to the plan)***

MEDICARE INFORMATION

This only applies when a member, spouse or covered dependent is age 65 and older OR on Medicare due to disability

	Medicare Number	Hospital – Part A Effective Date	Medical – Part B Effective Date	Entitlement due to Disability
Member				**Y or N**
Spouse				**Y or N**
Dependent				**Y or N**

Dependent Information

Full Name	Relationship	Date of Birth	Social Security Number
	Spouse		

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____

SIGNATURE **Date**

If you are not making changes to your current elections, you are encouraged to complete and return to address above