California Firefighters Benefit Trust

Administered By: Benefit Programs Administration

Telephone: (844) 353-7839 (213) 406-2370 **|** Facsimile: (562) 463-5894

E-Mail – scfirefighters@bpabenefits.com

www.FirefighterTrust.org

PARTICIPANT DATA FORM

Plan Participant Name: ____

Address: ____

____

Phone #: ______________________ Date of Birth: ______________________

Social Security #: ________________ Non- Work E-mail Address: ______________________

Participating Employer / Bargaining Unit: ______________________________

Date of Hire: ______________________ Date of Termination: ______________________

(with participating employer above) (if applicable)

Spouse / Domestic Partner: ____

Date of Birth: ______________________ Date of Marriage: ______________________

300300

Dependent Information:

Name: __________________________ Relationship: ______________________

Date of Birth: ______________________

Name: __________________________ Relationship: ______________________

Date of Birth: ______________________

Name: __________________________ Relationship: ______________________

Date of Birth: ______________________

I certify under penalty of perjury that the foregoing is true and correct. I understand that the Trust may pursue legal and equitable remedies and/or recoupment of benefits against me for any false, fraudulent or misleading information provided now or in other communications with the Trust Office.

______________________________ ______________________________

Participant's Signature Date