



NPFBA™



NATIONAL PEACE OFFICERS AND  
FIRE FIGHTERS BENEFIT ASSOCIATION™

*A Jointly Sponsored Long Term Care Trust of The California Law Enforcement Association® and  
The California Association of Professional Firefighters®*

LONG TERM CARE  
APPLICATION

PROTECTING THOSE WHO PROTECT THE PUBLIC

---

# INSTRUCTIONS FOR COMPLETING THIS APPLICATION

## **This Application must be completed by the Applicant.**

**When the Applicant signs this application he/she is making a certification under penalty of perjury that all answers are true and correct to the best of his/her knowledge.**

**NOTE:** Employee and Spouse must complete separate applications.  
All Incomplete Applications will be returned.

### **An application will be considered incomplete for any of the following reasons:**

- The signature blocks are not signed.
- The medical questions are not thoroughly explained.
- Any question or field is left blank.

All applications will be individually underwritten. If necessary, we will obtain your medical records and/or request a short paramedical exam to assist us in the underwriting process.

**All spouses applying for coverage are required to complete a paramedical exam at the expense of NPFBA as part of the underwriting process.**

**Please mail your completed application in the postage-paid envelope provided.**

**If this envelope was not provided to you, please mail to:**

**NPFBA**

Long Term Care Plan

PO Box 31

Martell, CA 95654-0031

Once your application is approved you may be required to sign the "Statement of Continuing Good Health" before coverage will be issued.

**If you have any questions about this Plan or if you need assistance in completing your application, please call toll free 877-582-0003, option #2. Our office hours are Monday through Friday 8:00 am to 5:00 pm.**

### **OFFICE USE ONLY**

Field Service Manager: \_\_\_\_\_

**Employees and their eligible spouses may apply for coverage through this Association.**

**All Applicants must complete all questions and sign and date where indicated.**

**Applicant must be age 60 or less and must fall into one of the following categories:**

1. Member of police department or fire department of municipal or public corporation or district including volunteers or reserves.
2. Peace or law enforcement officer who is a regular and salaried officer or employee of the state or of a single county or other political subdivision or public or municipal corporation.
3. Person who is an emergency medical services personnel and employed by a fire department of a city, county or district.
4. Person who at the time of becoming a member of such associations was qualified pursuant to paragraphs 1, 2, or 3 above.
5. Spouse of qualified employee pursuant to paragraphs 1, 2, or 3 above.
6. Retirees may not apply unless they are otherwise qualified in one of the above sections.

**The above list of qualified applicants would generally include County DA Investigators, County Probation Officers with peace officer status, State of California Investigators with peace officer status, Correctional Officers with the Department of Corrections of the State of California, California Highway Patrol Officers, County Correctional Officers, Firefighters, and CalFire Firefighters. Others who believe they qualify and are not listed above must contact the Plan Administrator to determine eligibility.**

I certify under penalty of perjury that I have read the above statement and agree that I qualify under the requirements stated above.

\_\_\_\_\_  
**Applicant**

\_\_\_\_\_  
**Date**

Have you met or discussed this coverage with a representative of NPFBA?  Yes  No

Name of representative: \_\_\_\_\_

If no, how did you hear about NPFBA Long Term Care Plan?

- Referral  Mailer  Poster  Website

## PLAN OPTIONS

### Check Applicable Box

**Plan 130/70/50**

\$130/Day Nursing Home  
70% Residential Care  
50% Home Health Care  
Respite Care Provision

**Plan 150/70/50**

\$150/Day Nursing Home  
70% Residential Care  
50% Home Health Care  
Respite Care Provision

**Group Plan/Negotiated Benefits Plan/Modified Payment Plan, may be available.**

Department/Plan: \_\_\_\_\_

## PAYMENT TERM

### Check Applicable Box

**25 Years**

**30 Years**

**35 Years**

**40 Years**

**45 Years**

*The maximum payment term is based on your age at time of application. Please see the published cost (rate) schedule to determine the length of time that you are allowed to make payments.*

**Payments must be fully paid by age 85.**

## APPLICANT INFORMATION

### Please Print

I am qualified to apply as a: *(Please choose the column that pertains to you, the applicant.)*

### Employee Applicant

- Active Full Time Firefighter
- Active Full Time Law Enforcement Officer
- Volunteer / Paid Call Firefighter
- Volunteer Law Enforcement Member
- Reserve Law Enforcement Officer
- Non-Safety Fire Dept. Employee
- Non-Safety Law Enforcement Dept. Employee

Department, Agency, or Association:

\_\_\_\_\_

Job Title: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

### OR Spouse Applicant

- Spouse of Active Full Time Firefighter
- Spouse of Active Full Time Law Enforcement Officer
- Spouse of a Volunteer / Paid Call Firefighter
- Spouse of a Volunteer Law Enforcement Member
- Spouse of a Reserve Law Enforcement Officer
- Spouse of a Non-Safety Fire Dept. Employee
- Spouse of a Non-Safety Law Enforcement Dept. Employee

My Employer: \_\_\_\_\_

My Spouse's Employer: \_\_\_\_\_

My Spouse's Name: \_\_\_\_\_

My Spouse's SS#: \_\_\_\_\_

Last Name		First Name			M.I.
Mailing Address		City	State	Zip	
Physical Address		City	State	Zip	
Home Phone Number	Best Time to Call	Social Security #	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Alternate Phone Number	Best Time to Call	Email			
Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age Last Birthday	
<b>Waist Circumference:</b> <i>Using a tape measure, start at the top of your hip bone and measure around your waist level with your belly button. Please make sure that the tape is straight and snug.</i>				in.	

## BENEFICIARY

**Please do not designate beneficiaries under the age of 18.**

**PRIMARY**

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Email: \_\_\_\_\_

**ALTERNATE (CONTINGENT)**

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Email: \_\_\_\_\_

## PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care coverage for nonpayment of dues. I understand that notice will not be given until thirty (30) days after payment is due and unpaid.

**I designate the following person(s) to receive notice prior to cancellation of my coverage for nonpayment:**

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**I elect not to designate any person to receive such notice.**

## PAYMENT OPTIONS

**Note:** Each Applicant will be billed on an individual basis (surcharges are per Applicant). Combined billing is not available.

**Please select one of the following methods of payment:**

**Monthly Bank Draft**

Please deduct my monthly payment from (choose one):

Checking       Savings

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Routing Number

\_\_\_\_\_  
Financial Institution Name

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Financial Institution Address including City, State & Zip

**Attach VOIDED check here. We are unable to process your application without this information.**

*I hereby authorize NPFBA or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authority will remain in effect until I provide written notification to cancel this Plan or my affiliation with NPFBA, its designated agent or my financial institution.*

*I understand that if the required funds are not on deposit in my account on the day designated to execute the automatic deduction, I will be subject to the payment collection provision shown in the Evidence of Coverage and that any charges for overdraft or insufficient funds may be charged to me along with any service charges applied by NPFBA.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Credit Card**

Annual     Semi-Annual (\$1.00 surcharge per transaction)     Quarterly (\$2.00 surcharge per transaction)

Type of Credit Card:     Master Card       Visa       Discover

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Signature

**Group Plan/Negotiated Benefits Plan/Modified Payment Plan.**

# MEDICAL INFORMATION & HISTORY

Please answer all of the following questions. If answering "Yes" to any question, please provide details in the space provided on page 10.

1. Are you employed or do you engage in hobbies, social activities, or volunteer work?  Yes  No
- 
2. Have you gained or lost more than 5 pounds in the past twelve (12) months?  Yes  No
- 
3. a. Are you receiving or have you applied for any type of Disability Benefits?  Yes  No  
b. Are you now, or have you ever received benefits from Medi-Cal or Medi-Care?  Yes  No  
c. Due to any present or past mental or physical disability, is any person or institution currently authorized to act on your behalf?  Yes  No  
d. Are you dependent on the use of a walker or wheelchair?  Yes  No  
e. Are you confined to your bed, home, hospital, or nursing home?  Yes  No  
f. Do you use any medical appliance such as a catheter, oxygen equipment, respirator, or a dialysis machine?  Yes  No
- 
4. Do you require assistance, supervision or are you limited in any way in performing any of the following daily activities: bathing, dressing, toileting, meal preparation, eating, mobility, housekeeping or managing medications?  Yes  No
- 
5. Have you ever been diagnosed or treated by a health care professional for stroke/ Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or cerebral aneurysm?  Yes  No
- 
6. Within the past 5 YEARS, have you been medically advised that you will need surgery, which has not been performed?  Yes  No
- 
7. When walking 4 blocks or climbing a flight of stairs, do you experience any difficulties such as shortness of breath, dizziness, leg cramps, pain, discomfort or restricted motion?  Yes  No
- 
8. Do you now, or have you ever, used any tobacco products including cigarettes, electronic cigarettes, cigars, pipes, chewing tobacco, marijuana, etc?  Yes  No  
a. How long have you or did you use tobacco products? \_\_\_\_\_  
b. If you have quit using tobacco or marijuana products, when was your last use? \_\_\_\_\_
- 
9. Have you ever used restricted or controlled substances except as prescribed by a licensed physician?  Yes  No
- 
10. Do you drink alcoholic beverages?  Yes  No  
a. If yes, please indicate number of drinks per day.  1  2  3  4 or more
- 
11. During the past 5 years, have you been counseled, treated or hospitalized for the use of alcohol or drugs?  Yes  No
- 
12. Do you, any health care providers or anyone else you know, have any concerns over your present health?  Yes  No
- 
13. In the last 5 years, has a health professional recommended that you should have any surgeries, tests, or procedures (including diagnostic & screening procedures) that have not been performed?  Yes  No

14. Have you ever been diagnosed or treated by a member of the medical profession or had symptoms of any of the following conditions? *(Please review the following list carefully. Place an X in the box next to those that apply. If you checked any of the following, please provide details on Page 10)*

- |   |  |
|---|--|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) / AIDS Related Complex (ARC) / HIV Positive   | <input type="checkbox"/> High Cholesterol  |
| <input type="checkbox"/> Attention-Deficit Disorder (ADD) or Attention-Deficit/Hyperactivity Disorder (ADHD)      | <input type="checkbox"/> Huntington's Chorea   |
| <input type="checkbox"/> Alcoholism, Drug or Substance Abuse  | <input type="checkbox"/> Hyperglycemic / Hypoglycemic  |
| <input type="checkbox"/> ALS (Lou Gehrig's Disease)   | <input type="checkbox"/> Incontinence / Bladder or Bowel Control                                     |
| <input type="checkbox"/> Alzheimer's Disease or Dementia  | <input type="checkbox"/> Joint Disorder or Replacement   |
| <input type="checkbox"/> Amputation   | <input type="checkbox"/> Kidney Disease or Failure   |
| <input type="checkbox"/> Aneurysm   | <input type="checkbox"/> Leukemia or Lymphoma  |
| <input type="checkbox"/> Angina   | <input type="checkbox"/> Lupus   |
| <input type="checkbox"/> Arrhythmia   | <input type="checkbox"/> Memory Loss or Cognitive Impairment   |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Meniere's Disease   |
| <input type="checkbox"/> Atrial Fibrillation  | <input type="checkbox"/> Mental / Nervous Disorder   |
| <input type="checkbox"/> Asthma, Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Chronic Lung Disease | <input type="checkbox"/> Motor Neuron Disease  |
| <input type="checkbox"/> Auto-Immune Disease  | <input type="checkbox"/> Metabolic Syndrome  |
| <input type="checkbox"/> Blood Clotting Disorder  | <input type="checkbox"/> Migraine or Chronic Headaches   |
| <input type="checkbox"/> Blood Disease: Anemia, Sickle Cell, or Bleeding Disorder                                 | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Bypass Surgery   | <input type="checkbox"/> Muscular Dystrophy  |
| <input type="checkbox"/> Cancer (External) Any Form   | <input type="checkbox"/> Obesity   |
| <input type="checkbox"/> Cancer (Internal) Any Form   | <input type="checkbox"/> Organ Transplant  |
| <input type="checkbox"/> Carotid Artery Disease   | <input type="checkbox"/> Organic Brain Syndrome  |
| <input type="checkbox"/> Cerebral Vascular Disease  | <input type="checkbox"/> Osteopenia / Osteoporosis   |
| <input type="checkbox"/> Cirrhosis of the Liver or other Liver Disease  | <input type="checkbox"/> Paralysis   |
| <input type="checkbox"/> Colitis  | <input type="checkbox"/> Parkinson's Disease   |
| <input type="checkbox"/> Congestive Heart Failure or Coronary Artery Disease                                      | <input type="checkbox"/> Peripheral Neuropathy   |
| <input type="checkbox"/> CPAP or BiPAP Machine  | <input type="checkbox"/> Vascular Disease  |
| <input type="checkbox"/> Cystic Fibrosis  | <input type="checkbox"/> Psychiatric Disorder (Anxiety Disorder, Depression, Bipolar Disorder, etc.) |
| <input type="checkbox"/> Diabetes, Diabetes with Insulin or Pre-Diabetic  | <input type="checkbox"/> Raynaud's Syndrome  |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Retinitis Pigmentosa  |
| <input type="checkbox"/> Eating Disorders: Anorexia, Bulimia  | <input type="checkbox"/> Rheumatoid Arthritis  |
| <input type="checkbox"/> Fibromyalgia or Chronic Fatigue  | <input type="checkbox"/> Schizophrenia   |
| <input type="checkbox"/> Fractures  | <input type="checkbox"/> Scleroderma   |
| <input type="checkbox"/> Glaucoma, Macular Degeneration or other Eye Disorder                                     | <input type="checkbox"/> Seizure Disorder  |
| <input type="checkbox"/> Heart Attack, Angioplasty or Coronary Stent  | <input type="checkbox"/> Single / Multiple Transient Ischemic Attack (TIA)                           |
| <input type="checkbox"/> Heart Valve Impairment or Replacement  | <input type="checkbox"/> Sleep Apnea or Sleep Disorders  |
| <input type="checkbox"/> Hemophilia   | <input type="checkbox"/> Spine or Back Disorders including Scoliosis                                 |
| <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Tremor  |
|   | <input type="checkbox"/> Weight Loss Surgery: Gastric Bypass, Lap Band or other method               |

**Check this box if you have not been diagnosed or treated for any of the conditions listed above.**



*If you answered yes to any of the following, please provide details on Page 10.*

15. Have you ever been diagnosed, advised of, or received medical treatment by a member of the medical profession for any condition not listed in question 14 (other than routine physical exams with normal findings)?  Yes  No

16. During the past 5 YEARS, have you: *(Place an X in the box next to those that apply)*

a. Sought medical advice or treatment for any of the following conditions?  Yes  No

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Confusion/Disorientation | <input type="checkbox"/> Falling          | <input type="checkbox"/> Pain, Tingling, Hot or Cold Sensation |
| <input type="checkbox"/> Deterioration of Vision  | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Tremors                               |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Numbness         | <input type="checkbox"/> Unstable Gait                         |

b. Used or been advised to use any of the following:  Yes  No

- |                                 |                                  |                                       |
|---------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Braces | <input type="checkbox"/> Scooter | <input type="checkbox"/> Wheelchair   |
| <input type="checkbox"/> Cane   | <input type="checkbox"/> Walker  | <input type="checkbox"/> Other: _____ |

17. Do you have or have you ever had a pending or active Workers' Compensation Claim?  Yes  No

18. Have you ever had genetic testing?  Yes  No

If yes, what for: \_\_\_\_\_

Outcome: \_\_\_\_\_

19. Have you been hospitalized, been advised to have, or had surgery, medical care, EKG, x-ray, imaging, diagnostic test, cardiac testing, sleep studies or confined to any facility in the last five (5) years? *If yes, please provide details below. Additional space on page 10.*  Yes  No

Test Performed	Date	Reason	Results	Name & Contact Information of Medical Advisor

20. Do you live alone? If no, who lives with you? \_\_\_\_\_  Yes  No

21. Do you drive? If no, why?  Yes  No

a) Has your driver's license ever been suspended?  Yes  No

22. Have any of your natural parents, brothers or sisters, either living or dead, ever suffered from any of the following conditions: Polycystic Kidney Disease, Cystic Fibrosis, Hemophilia, Multiple Sclerosis, Huntington's Chorea, Motor Neuron Disease, Muscular Dystrophy, Alzheimer's, Dementia or any other form of inherited disease?  Yes  No

*If yes, please provide details on page 10*



## MEDICATIONS AND SUPPLEMENTS

List ALL Medications and Supplements you use regularly OR have regularly used within the past 5 YEARS. Please include prescription medications, non-prescription medications (Over the Counter – OTC), and dietary supplements.

Medication/Supplement	Reason, Frequency and Dosage	Currently Use
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

I do not take any medications or supplements.

*Please attach additional page if necessary.*

## PHYSICIAN INFORMATION

Please provide information for primary physician and any additional treating physicians.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Applicant's Kaiser, HMO, PPO, or Medical I.D. Number: \_\_\_\_\_

Have you been seen by any other physician and/or medical facility in the past 5 YEARS?     Yes     No

Please provide additional physician's name, address, phone number and reason/outcome for visit. *Additional space on page 10.*

1. \_\_\_\_\_

2. \_\_\_\_\_

## OTHER LONG TERM CARE

1. Do you now have in force, or are you applying for, any other long term care, nursing home or home health care policy, rider or certificate (including a health care service contract, a health maintenance organization contract, or health insurance policy)?     Yes     No

*Please provide company names for the purpose of benefit coordination:*

\_\_\_\_\_

2. Other than the above, did you have a long term care policy, rider or certificate in force during the last 12 months?     Yes     No

*If yes, please explain:* \_\_\_\_\_

3. Have you ever had an application for Life, Health or Long Term Care insurance declined, postponed, modified or rated?     Yes     No

*If yes, please explain:* \_\_\_\_\_

# APPLICANT CERTIFICATION

I certify that I have reviewed all the information and notices contained in this application and that all information supplied on this application is true to the best of my knowledge.

I also understand and agree that the coverage for which I am applying, if issued, shall be subject to these statements and will take effect on the effective date stated on the schedule of benefits. If statements in this application are fraudulent or materially misrepresented, sanctions that could include rescission of my coverage or a benefit denial may be applied. If I have submitted intentionally fraudulent statements, I understand that my name may be submitted to the relevant authority for criminal prosecution.

I understand that the Plan I am applying for has been approved by the Trustees of the National Peace Officer and Fire Fighters Benefit Association (NPFBA), but does not qualify for Medi-Cal spend-down protection under the California Partnership for Long Term Care.

I understand that based on the medical information provided, I may receive a preferred, standard, or modified rating. The standard rating will have an elimination period of 90 days, while the preferred rating will have an elimination period of 60 days. A modified rating will be an elimination period agreed upon by the applicant and the Trust. Modified ratings are sometimes offered in lieu of a denial of coverage. Certain other riders and exclusions may be added to the certificate with agreement of both parties. I will have the opportunity to accept or deny the certificate if it is not issued on a preferred basis. If I deny the certificate of coverage, I will receive my full-prepaid payment within 30 days of my decision.

Additionally, I understand that if I use or if I have used any tobacco or marijuana products within the last 36 months, I will be issued a certificate of coverage on a standard basis and I will automatically have a 90-day elimination period if my application is approved by NPFBA.

This coverage will not be effective until the "Statement of Continuing Good Health" has been signed and returned on a form provided by the Administrator. This Statement of Good Health confirms that all information on the initial application continues to be correct and that nothing has changed since the original application was submitted.

**No coverage will be provided for any job related injury or an injury caused by a third party where a cash settlement was provided in lieu of future medical coverage. Keep this in mind whenever you are offered cash in lieu of future medical coverage. This is particularly important in workers' compensation claims.**

**I have read and understand the above statements concerning information that may be fraudulent or misrepresented, and the probable penalty of making such statements.**

**I agree that I shall abide by the related provisions as noted in the NPFBA Plan Documents and Corporate Bylaws. Under the terms of the Plan, any dispute not resolved through the Plan's claim procedure will be resolved by binding arbitration with the American Arbitration Association.**

---

Signature of Applicant

Date

**I certify that the information in this application for Long Term Care (LTC) coverage with the National Peace Officers and Fire Fighters Benefit Association Trust is accurate and complete to the best of my knowledge.**

---

Print Name as it appears in Applicant Information of Application

---

Social Security Number

---

Date of Birth



NPFBA™



NATIONAL PEACE OFFICERS AND  
FIRE FIGHTERS BENEFIT ASSOCIATION™

*A Jointly Sponsored Long Term Care Trust of The California Law Enforcement Association® and The California Association of Professional Firefighters®*

1-877-582-0003 · (209) 223-3971 · PO BOX 31 · MARTELL, CA 95654-0031 · FAX (209) 223-2966 · WWW.NPFBA.ORG

# HIPAA Authorization

**Must be completed for application to be processed.**

**Who May Request or Use Information:** This information may be disclosed to and used or disclosed by: National Peace Officers and Fire Fighters Benefit Association (NPFBA), California Public Safety Administrators, Inc. (Plan Administrators for NPFBA), ExamOne, or an evaluating physician.

**Who is Authorized to Disclose Information:** All of the following persons or entities are authorized to disclose any and all individually identifiable health information or records about me including but not limited to medical records, reports, pharmaceutical records, drugs, diagnostic testing, and lab work: licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, pharmacy related service organization or medically related facility, the Veterans Administration, care provider or evaluators, or other organization, institution or person that has knowledge or records of me and my health.

I also agree and understand that:

- this authorization is needed for the purpose of gathering information for making eligibility, underwriting, and risk rating determinations.
- If I do not sign this authorization, my application for long-term care coverage under the NPFBA Long Term Care Plan may not be processed and my eligibility for long-term care benefits under the Plan may be denied.
- I may revoke this authorization at any time, except to the extent that:
  - action has already been taken in reliance on it before my revocation, or
  - NPFBA has a right to contest my long-term care benefits claim or coverage.
- To revoke this authorization, I must notify the NPFBA, PO Box 31, Martell, CA 95654, in writing.
  - If I do revoke this authorization, I understand that my application for long-term care coverage may not be processed and my eligibility for long-term care coverage benefits may be denied.
  - If I do not revoke this authorization, it will be valid for 36 months from the date I sign it, at which date it will expire.
- My health information may be redisclosed and may be no longer protected by applicable law, including Federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (for example, in response to a subpoena).
- A copy of this authorization is as valid as the original.

By my signature below, I attest that I have read and understand the terms of this authorization and that I agree to the terms of this authorization.

\_\_\_\_\_  
Applicant Name *(Please print)*

\_\_\_\_\_  
Signature of Applicant

Last 4 of SS# \_\_\_\_\_ Date \_\_\_\_\_



**NPFBA™**



NATIONAL PEACE OFFICERS AND  
FIRE FIGHTERS BENEFIT ASSOCIATION™

**1-877-582-0003, Option #2 • Fax (209) 223-2966**

**PO Box 31 • Martell, CA 95654-0031**