Florida Fire Fighter's Insurance Trust Fund

ENROLLMENT/CHANGE FORM

Effective Date: _____ Member City ID#_____

Reason for Submission

☐ Initial Application ☐ Change of Dependent ☐ Change of Name ☐ Change of Plan

☐ Change of Salary ☐ Change of Beneficiary ☐ Other:_____ _____

☐ Termination of Dependent Coverage: Dependent Name: Termination Date: _____

Employed with (Circle) : Hialeah Miami Beach Coral Gables

Name (Last, First, MI):			
Address (Street)	City	State	Zip Code
SS#:	DOB:	Sex:	
Marital Status:	Hire Date:		
Home#:	Cell#:		
Email :			

List All Family Members electing Dependent Coverage:

Last Name	First Name	MI	SS#	Relationship	Sex	DOB

Please use Life Insurance form to list beneficiaries for the Life Insurance Policy.

Employee Certification: I declare that in the best of my knowledge and belief, all of the statements and answers given above are correct.

Employee's Signature: X_____ Date:_____

Employer's Signature: X_____Date:_____