



Municipality of Anchorage
 RETIREE MEDICAL FUNDING PROGRAM TRUST
 FOR POLICE OFFICERS AND FIREFIGHTERS

Authorization and Dependent Update Form

Check if new Address

Name: _____
 Address: _____

Retiree ID: _____
 Phone: _____
 Email: _____

Dependent, Spouse (Please include dependent backup documentation, if not already on file.)

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change	<input type="checkbox"/> Full Time Student <input type="checkbox"/> Has Other Coverage <input type="checkbox"/> Over 19 and Disabled	SS#	
Name		Relationship	Birth Date
			Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Address		City	State Zip Code
↑			

<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Change	<input type="checkbox"/> Full Time Student <input type="checkbox"/> Has Other Coverage <input type="checkbox"/> Over 19 and Disabled	SS#	
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Name		Relationship	Birth Date
			Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Address		City	State Zip Code
↑			

I hereby authorize the Police and Fire Retiree Medical Trust to communicate with
 _____ **regarding all reimbursement requests and benefit information.**

Signature: _____ **Date:** _____