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

Authorization and Dependent Update Form

☐ Check if new Address

Name: ______________________ Retiree ID: ______________________
Address: ______________________ Phone: ______________________
______________________ Email: ______________________
____

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

☐ Add ☐ Drop ☐ Change	☐ Full Time Student ☐ Has Other Coverage ☐ Over 19 and Disabled		SS#		
Name	Relationship		Birth Date	Gender ☐ Female ☐ Male	
Address		City		State	Zip Code

☐ Add ☐ Drop ☐ Change	☐ Full Time Student ☐ Has Other Coverage ☐ Over 19 and Disabled		SS#		
Name	Relationship		Birth Date	Gender ☐ Female ☐ Male	
Address		City		State	Zip Code

☐ Add ☐ Drop ☐ Change	☐ Full Time Student ☐ Has Other Coverage ☐ Over 19 and Disabled		SS#		
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Name	Relationship		Birth Date	Gender ☐ Female ☐ 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:** ______________

PO BOX 196650 ANCHORAGE, ALASKA 99519 * PH (907) 267-5094 * (877) 343-8203 *
FX (907) 249-7622 * www.muni.org/pfrmt

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