Professional Firefighters and Paramedics Benevolent Fund, Inc.
7240 7th Place North
West Palm Beach, Florida 33411
561-727-3953

Dear Benevolent Member:

Attached is the Application for Benefits (FORM 09-002C) which is used to request **TIME ONLY** from the Benevolent Fund. As part of the Application of Benefits, additional documentation is required as noted below.

Your Application for Benefits will not be considered for review unless you have signed and NOTARIZE the application. Your signature will also be required on an Authorization to Release Medical and Financial Records.

Once the obligations of the Benevolent Fund have been met as agreed upon in this application and as approved by the Board of Trustees, your Application for Benefit will then be considered complete and inactive. Any additional need for benefits will require a new Application for Benefit.

In accordance with the CBA, Benevolent Fund hours or financial assistance shall not be utilized to supplement the sick leave hours required of an employee when utilizing Extended Leave. Members must have exhausted all accumulated leave balances in order to be eligible to be awarded hours from the Benevolent Fund. The Benevolent Fund will not offset wages lost due to being out of pay status.

Once complete, please give this application to the Chair or the Secretary and it will then be reviewed at the next scheduled meeting of the Benevolent Fund.

DOCUMENTATION CHECKLIST

Please make sure you have all of these documents included with the application.

The following documents must be attached to this Application for Benefits, missing information will delay your application or cause your application to be denied.

____ Photocopy of driver's license or other government issued photographic identification.

____ Supplemental Insurance Information or policy copy

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Application for Benefits – Time Only
Member Information

Name:_____
Address:_____
Drivers License_____ DOB_____
Marital Status_____

Spouse/Significant Other Information
Name:_____
Drivers License_____ DOB_____
Employer_____

Dependent Information

Relationship to Applicant	Gender	DOB	Name

TIME NEEDED:_____

Do you have any voluntary supplemental insurance policies (eg. AFLAC, long term heath, hospital indemnity, critical illness, disability, etc.)? Yes _____ No _____

If yes, please provide us the policy number, type and verification information or policy copy.

Reason Benefits are Requested
(please provide us with as much information necessary to evaluate this application for benefits)

_____

_____

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_____

Member Acknowledgement:
To the best of my knowledge, all of the information supplied in this application is true and correct and I agree to the policies and procedures set forth by the Benevolent Fund. I also understand that I am solely responsible for all shift exchanges while using benevolent fund time and that the Benevolent will not be held responsible for this time.

_____
Applicant Name (please print)

_____ _____
Applicant Signature Date

Notary Public:
Signed and sworn to (or affirmed) before me on _____by_____ (name of affiant). He/she is personally known to me or has produced _____type of identification as identification.

_____ _____
Signature Print name

Professional Firefighters/Paramedics Benevolent Fund, Inc.
Authorization to Release Medical and Financial Records

I hereby authorize any authorized representative of the Professional Firefighters/Paramedics Benevolent Fund, Inc. (Benevolent Fund) bearing this release, or copy thereof, to obtain any information in your files pertaining to my medical records, including history, diagnosis, treatment, and prognosis. I hereby direct you to release such information upon the request of the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the Benevolent Fund. I hereby release you, as the custodian of such records, and any physician, hospital, or other repository related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, my family, or associates, because of compliance with this authorization and request to release information, or attempt to comply with it. Should there be any questions as to the validity of this release, you may contact me as indicated below.

Any person who knowingly and with intent to defraud files this Application for Benefits (application), or any information contained within this application with false information or conceals for the purpose of misleading information concerning any material fact hereto, or any person who assists in the filing of this Application for Benefits, commits a fraudulent act that is a crime. In the event that such a fraudulent application is submitted by the applicant or anyone else, this application may be immediately disqualified, the full sanctions under the law would be followed, and the eligibility of such person submitting or being a party to such a fraudulent application would be suspended for a period to be determined by the Benevolent Fund. In the event any money or any other benefit is paid as a result of such a fraudulent application, which is determined as fraudulent, the full penalty of the law will be applied, the amount of the payment will be recovered with interest and the person's eligibility for all benefits provided by the Benevolent Fund would be indefinitely suspended. Such recovery for any fraudulent act may also include all collection costs, which includes, but is not limited to the following: medical investigation charges, auditors' fees, and attorneys' fees, as necessary, whether suit is filed or not, and court costs.

I hereby authorize any authorized representative of the Benevolent Fund bearing this Authorization to Release Medical and Financial Records (Authorization), or copy thereof, to obtain any information in your files pertaining to my financial records, to include all bank records, federal and state income tax returns, credit or credit union records, or any other financial transactions. I hereby direct you to release such union records, or any other financial transactions. I hereby release you, as the custodian or repository of financial records, including its officers, employees or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family, or associates because of compliance with this Authorization, or attempt to comply with it. Should there be any questions as to the validity of this Authorization, you may contact me as below.

Applicant's Name: _____

Applicant's Home Address: _____

City, State and Zip Code: _____

Telephone(s): Cell: _____Home _____ Work _____

Applicant's Name (please print): _____

Applicant's Signature: _____ Date: _____

----- END OF FORM 09-002C ----