



# California Association of Professional Firefighters

## CAPF SAFETY LONG TERM DISABILITY ENHANCED INDIVIDUAL PLAN APPLICATION

**Send your completed application using one of these convenient options:**

**Scan and email: [accounting@capf.org](mailto:accounting@capf.org) • Mail: CAPF, PO Box 31, Martell, CA 95654 • Fax: (209) 223-2966**

*Please contact the Plan Administrator at (800) 832-7333 with any questions.*

Last Name	First Name	M.I.	Birth Date / /	Social Sec. No.
Mailing Address				Employment Date / /
City	State	Zip Code	Phone ( )	
<b>Employment Designation</b> <input type="checkbox"/> Safety	Department	E-Mail Address		

**PLEASE SELECT ONE OF THE FOLLOWING METHODS OF PAYMENT**

<input type="checkbox"/> <b>Monthly Bank Draft</b> <input type="checkbox"/> <b>Checking</b> <input type="checkbox"/> <b>Savings</b> Financial Institution _____ Account # _____ Routing # _____	<input type="checkbox"/> <b>Credit Card</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual (\$1.00 surcharge per transaction) <b>Type of Credit Card:</b> <input type="checkbox"/> Master Card <input type="checkbox"/> Visa <input type="checkbox"/> Discover Card Number _____ Exp. Date _____
<input type="checkbox"/> <b>Annual Payment - \$354.00</b> (Make check payable to CAPF)	

**I hereby apply for Enhanced Individual Long Term Disability (LTD) Benefits** and certify that I am a Permanent, Full-Time Firefighter II, Apparatus Engineer or Officer within the safety retirement system. A person is not eligible to enroll after he or she is 60 years of age or more.

I agree that I shall abide by the related provisions as noted in the Plan Documents and Corporate Bylaws. I understand that any medical condition including HIV, AIDS, ARC that existed prior to my effective date of coverage or death caused by pre-existing medical conditions will not be covered until I have been enrolled in the Plan as an Active Participant for a period of sixty (60) months. Disabilities occurring after my effective date of coverage caused by psychological or emotional disorders, or their physical manifestations, or drug, alcohol, or substance abuse, will be covered after 24 months of participation unless condition is excluded because of pre-existing medical condition. Under the terms of the Plan, any dispute not resolved through the Plan's claims procedure must be resolved by binding arbitration with the American Arbitration Association. CAPF reserves the right to increase dues periodically as determined by the Board of Directors.

Beneficiary information is required for the Plan Death Benefits. Contact the Plan Administrator at 1-800-832-7333 or visit [www.CAPF.org](http://www.CAPF.org) to update your beneficiary choice or for additional information.

**By signing below I indicate that I have read these statements including the Special Note on the Pre-Existing Conditions and the Special Provisions and acknowledge the limitations in LTD Benefits as explained. Other conditions and limitations are included in the CAPF Plan Document and Summary Plan Description.**

**If choosing monthly bank draft or credit card, I hereby authorize CAPF or its designated agent and the financial institution named below to initiate withdrawals from my checking/savings account or credit card as specified. This authorization will remain in effect until cancelled by me or CAPF.**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
(Please do not list minors)

Beneficiary Address \_\_\_\_\_ Beneficiary Phone \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
(Please do not list minors)

Contingent Beneficiary Address \_\_\_\_\_ Contingent Beneficiary Phone \_\_\_\_\_

**Please do not write in this space. Office use only.**

Received: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Dept.: \_\_\_\_\_ Cert. No.: \_\_\_\_\_ SPD Sent: \_\_\_\_\_