DADE COUNTY FIRE FIGHTERS INSURANCE TRUST
STANDARD LIFE INSURANCE COMPANY
ACTIVE MEMBER POLICY #645783

Member Name:_____ **Sex: Male or Female** (Circle)

Date of Birth:_____/_____/_____ **Social Security #** _____ - _____ - _____**Employee ID#**_____

Station:_____ **A B C 40 hr**. Hire Date:____/_____/_____ **Cell#** (_____) _____ - _____

Home Phone: (_____) _____ - _____ **E-mail Address**_____

Address _____ **City** _____ **State:** _____ **Zip Code:**_____

As a participant/member of the **Dade County Fire Fighters Insurance Trust** you are entitled to a Life Insurance benefit equal to:

One Time your **Annual Salary** for **Normal Death Benefit**
Two Times your **Annual Salary** for **Accidental Death (ON & OFF DUTY)**

Primary Beneficiary (ies)

Name and Address	Percent %	Relationship	Date of Birth	Social Security#

Contingent Beneficiary (ies)

Name and Address	Percent %	Relationship	Date of Birth	Social Security#

Proper notarization and signature must be obtained to validate beneficiary designations.

★ **Signature** _____ **Date** _____

State of Florida

SS:

County of Miami-Dade

Before me on this _____ day of _____, 20_____ personally appeared the above individual and swore the information contained herein to be true and of his/her free will.

_____**Notary Public, State of Florida**

☐ Personally Known ☐ Produced Identification ☐ Identification Produced _____

Any person who knowingly & with intent to defraud, submits an application, files a statement of claim containing any material false or misleading information, commits a fraudulent act, which is a crime. Subject to revocation by me by written notice to my employer, I request the coverage provided from time to time by my employers group plan(s), as elected above and authorize deductions (if any) from my wages.

*****Underwritten by STANDARD LIFE INSURANCE COMPANY, PORTLAND, OR******