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 • 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
			( )

Employment Designation	Department	E-Mail Address
☐ Safety		

PLEASE SELECT ONE OF THE FOLLOWING METHODS OF PAYMENT

❑ **Monthly Bank Draft**

❑ **Checking** ❑ **Savings** Financial Institution _____

Account # _____ Routing # _____

❑ **Credit Card** ❑ Annual ❑ Semi-Annual ($1.00 surcharge per transaction)

Type of Credit Card: ❑ Master Card ❑ Visa ❑ Discover Card

Number _____ Exp. Date_____

❑ **Annual Payment - $294.00** (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 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:_____