

WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-2099

MEMBER INSURANCE COVERAGES

This form is to be completed by the LEOFF I member annually and mailed directly to member's employer/employer member is retired from. List all sources of medical insurance coverages, i.e. Medicare, medical benefits plans, group policies, or prepayment plans.

LEOFF I Member Name: _____
LEOFF I Member SSN: _____
Employed By/Retired From: _____

Insurance Provider Name: _____
Insurance Provider Address: _____
Insurance Provider Phone: _____
Insurance Provider Fax: _____
Insurance Provider Email: _____
Insurance Policy Number: _____

Insurance Provider Name: _____
Insurance Provider Address: _____
Insurance Provider Phone: _____
Insurance Provider Fax: _____
Insurance Provider Email: _____
Insurance Policy Number: _____

Insurance Provider Name: _____
Insurance Provider Address: _____
Insurance Provider Phone: _____
Insurance Provider Fax: _____
Insurance Provider Email: _____
Insurance Policy Number: _____

Insurance Provider Name: _____
Insurance Provider Address: _____
Insurance Provider Phone: _____
Insurance Provider Fax: _____
Insurance Provider Email: _____
Insurance Policy Number: _____

I certify that I have answered truthfully and have not knowingly withheld any information relative to my medical insurance coverages.

MEMBER NAME
WCLIB #13

DATE