WHITMAN COUNTY LEOFF I BOARD
400 N Main Street, Colfax, WA 99111
(509) 397-5246
FAX (509) 397-6355

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: ______________________

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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 **DATE**

WCLIB #13