LOS ANGELES FIREMEN'S
RELIEF ASSOCIATION
P.O. Box 41903 | Los Angeles | CA 90041
(323) 259-5200 EXT. 223 or 222 firemensrelief.org

NIOD STATEMENT

MEMBER INFORMATION

FULL NAME *(FIRST, MIDDLE, LAST)*		LAST 4 DIGITS of SSN		BIRTH DATE
ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS		

STATUS ☐ ACTIVE Assignment _____ ☐ RETIRED

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ DOMESTIC PARTNER

I, _____ , state that the Relief claim I am filing for,
(Full Name)

_____ is an NIOD illness/injury.
(Name of illness or injury)

If the illness or injury is changed to IOD, all Relief Benefits paid to me will be refunded to the Los Angeles Firemen's Relief Association. I will protect LAFRA's right to reimbursement by pursuing appropriate legal remedies and recognize LAFRA's right to file a lien in any such proceedings.

_____ _____

Member Signature **Date**