



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)			BIRTH DATE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS	
STATUS <input type="checkbox"/> ACTIVE Assignment _____ <input type="checkbox"/> RETIRED	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 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