Please print and mail to: NPFBA, PO Box 31, Martell, CA 95654

SUPPLEMENT TO THE APPLICATION

IMPORTANT NOTICE

Your Long Term Care (LTC) coverage will not be effective until you complete, sign, date and return this form to the Administrator. Once it is received, we will mail the Certificate of Coverage along with any necessary billing statements.

UPDATED HEALTH STATEMENT

This supplement is considered a portion of the original application to determine coverage under the National Peace Officers and Fire Fighters Benefit Association (NPFBA) Long Term Care Plan

Part A is to be completed if there has been no change in health of the proposed applicant and/or Part B is to be completed if there has been a change in health of the proposed applicant.

A. ☐ No change in health for ______________________________

(First and Last name of Applicant)

I declare that since the date of the original application submitted to NPFBA

1. The health, mental and physical condition of the applicant named above to be covered under the NPFBA LTC Plan has not changed; and
2. that any person named above proposed for coverage under this application has not had any illness or injury, consulted or been examined by a physician, had life, accident, health, or LTC coverage postponed, rated up, ridered, declined, cancelled or renewal of reinstatement refused.

B. ☐ Change in Health for ______________________________

(First and last name of Applicant)

Please provide details below:

Name of Proposed Applicant	Date of Visit	Reason for Medical Consultation/Treatment	Name and Address of Doctor

I represent that to the best of my knowledge and belief, these statements are complete and true and agree that this statement and the answers given herewith will be made part of the new coverage, if issued.

______________________ ______________________ ______________________

Proposed Applicant (Signature) Print Name Date

Revised 5/10