

**Apply NOW for PYI**  
(unfortunately, seasonal firefighters not eligible)

CDFD Local 2881

Instructions: Use ink and complete each section of this application, including details of any injury or illness for which you received (or should have received) medical treatment, counseling or therapy. Failure to disclose a pre-existing medical condition or injury may result in a denial of your claim for benefits under the PYI Plan. Be accurate and thorough in your description of any previous injury, condition or illness that required attention. **PLEASE PRINT**

First name \_\_\_\_\_ Last name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Home ph \_\_\_\_\_ Work ph \_\_\_\_\_ Cell ph \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Monthly Salary \$ \_\_\_\_\_

Hire Date (permanent civil service employee) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Classification/Rank \_\_\_\_\_

Are you actively at work?\*\*\* Yes  No  If no and you are off on a disability, what is your anticipated Return to Work date? \_\_\_\_\_

Marital status \_\_\_\_\_ Name of spouse \_\_\_\_\_

Have you or your spouse used ANY TYPE of tobacco in the past 12 months? Member Yes  No  / Spouse Yes  No

Beneficiary name \_\_\_\_\_ Relationship \_\_\_\_\_

1. Have you ever: (a) had, (b) been advised by a physician that you had, or (c) received advice or treatment for: (Circle the conditions that apply and explain below).

If you are not sure about an answer, your physician will be able to provide you with the information.

A) Heart or artery disorder, tuberculosis, liver disorder, kidney trouble, lung or other respiratory issues? Yes  No

B) High blood pressure? Yes  No  **If yes, last 2 readings and dates** \_\_\_\_\_

C) Diabetes? Yes  No  **If yes, age of onset, how controlled?** \_\_\_\_\_

D) Cancer, leukemia, malignant growth or any form of tumor? Yes  No

E) Epilepsy or any mental/nervous disorder? Yes  No

F) Alcoholism or any drug or substance abuse? Yes  No

G) a. Any disorder of the immune system, including AIDS and AIDS related complex? Yes  No

b. Tested positive for antibodies to AIDS (Human Immunodeficiency virus; HIV)? Yes  No

2. Other than the above, have you in the past five years had any disorder or injury not listed here? Yes  No

3. Have you had a physical examination in the past five years? Yes  No  **(If yes, give details below regarding reason for exam)**

4. Are you: A) Under medical observation for any reason? Yes  No  B) Taking medication for any reason? Yes  No

<i>Condition</i>	<i>Medication</i>	<i>Dosage and Frequency</i>

If any "yes" answers to questions 1 through 4, please explain below.

Ques no.	Name of individual	Condition, injury, symptom, of ill health or findings of examination (if surgery preformed, state type)	Onset Date mo/yr	Date of last treatment	Degree of recovery	Name and address of attending physician

If hospitalized, name and address of hospital \_\_\_\_\_

**AmeriDoc UPGRADE:**

\_\_\_\_\_ **\*\*YES**, please upgrade my AmeriDoc Benefit to include my family. This benefit will eliminate all consultation fees and provide myself and spouse with annual adult wellness blood test (usual cost: \$300)

**Monthly Cost: \$23.00**

\_\_\_\_\_ **NO**, I do not wish to upgrade at this time.

\*\* If **YES**, complete Dependent Information: (please print)

	First Name	Last Name	Date of Birth	
Spouse:	_____	_____	__-__-__	Male/Female (circle one)
Child:	_____	_____	__-__-__	Male/Female
Child:	_____	_____	__-__-__	Male/Female
Child:	_____	_____	__-__-__	Male/Female
Child:	_____	_____	__-__-__	Male/Female
Child:	_____	_____	__-__-__	Male/Female

By taking the upgrade, I understand that this plan is not health insurance and it is not intended as a substitute for health insurance.

I HERBY (1) request coverage under Protect Your Income plan as described in the Certificate of Coverage prepared by California Professional Firefighters Health Benefits Trust, (2) authorize required deductions, if any, from my earnings; (3) represent that my answers to the foregoing questions, and any statements made above are true and complete, and that every occasion and instance to each item answered "yes" has been disclosed; (4) understand that among the requirements for participation in the PYI Plan is that I remain a member in good standing of the California Professional Firefighters and am actively at work\*\* as a firefighter. **Mail to: CPFHBT, PO Box 27020, Fresno CA 93729-7020**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Authorization for Payroll Deduction:** \_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

On the reverse side of this form I have applied for insurance for which I am now eligible under the provisions of the Group Policy issued to CPFHBT and I authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.

Member's signature: \_\_\_\_\_ Date: \_\_\_\_\_

I am interested in the other types of insurance offered through the CPF Health Benefits Trust (Harry J. Wilson INSURANCENTER Inc. / United Valley Insurance Agency). Please contact me about:

- Home
- Auto
- Renter's Insurance
- Boat
- RV
- Health Insurance
- Other: \_\_\_\_\_

*PYI open enrollment: November 1 through December 31*

For more coverage information and frequently asked questions about the PYI Plan please visit [www.cdf-insurance.com](http://www.cdf-insurance.com) or contact

**CPFHBT Administrator**  
**Harry J Wilson INSURANCENTER Inc.**