

Collingdale Volunteer Firemen's Relief Association
Insurance and Beneficiary Data Sheet

INSURED NAME:

Last Name: _____ First Name _____ MI: _____ SR/JR: _____
Address: _____ APT # _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Fax Phone: _____
Insured's Email Address: _____
Insured's Social Security #: _____ Insured's Date of Birth: _____
Fire Company Affiliation: _____

DESIGNATED BENEFICIARY (S):

1. Relationship to Insured: _____
Last Name: _____ First Name: _____ MI: _____ SR/JR: _____
Address: _____ APT # _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Email Address: _____

2. Relationship to Insured: _____
Last Name: _____ First Name: _____ MI: _____ SR/JR: _____
Address: _____ APT # _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Email Address: _____

3. Relationship to Insured: _____
Last Name: _____ First Name: _____ MI: _____ SR/JR: _____
Address: _____ APT # _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Email Address: _____

Signature of Insured: _____ Date Signed: _____
Signature of Parent/Guardian: _____ Date Signed: _____

** (If Insured is under the age of 16) **

FOR RELIEF ASSOCIATION USE ONLY

Date Claim Received: _____ Date Claim Posted: _____
Date Claim Filed: _____ Date Claim Paid: _____

Claim Check/Draft Number