



Organization: _____



MEMBER ROSTER

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This is a multi-purpose form and not all columns are required. Please see the bottom of the page for instructions.

<u>Member Name</u>	<u>Gender</u> (M/F)	<u>24 Hr</u>		<u>Rank or Position</u>	<u>Birth Date</u>		<u>Service Start</u>		<u>Regular Occupation</u>
		<u>Single</u>	<u>Family</u>		Month	Year	Month	Year	

For 24 Hour Off Duty Injury please complete columns 1 and 3. That is Name followed by whether coverage is to be Single or Family.
For Critical Illness or Group Life Insurance please complete column 2 for Gender and 5 for Birth Date.
For Health and Dental please complete column 1 for Name and 6 for date Service Started. Columns 4 and 7 are optional.

Date: _____