Garden Grove Police Association Medical Trust
Medical Reimbursement Claim Form

Required Information

Retiree Information

Last Name	First Name	Middle Initial		
Address	City	State	Zip	Check Here ___ If new address
Day Phone			Night Phone	
Date of Claim			Amount Claimed	
I am currently:	Single	Married	Divorced	
I have qualified dependants:	Yes	No	If yes, how many?	

Complete this section if this is your first claim or if there are any changes since your last claim

Retiree's Social Security Number	Total Sworn Years at G.G.P.D.
Retiree's G.G.P.D. Sworn Hire Date	G.G.P.D. Separation Date

Spouse Information

Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	Date of Marriage

Dependant Information

Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	
Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	
Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	

Health Insurance Information

Name of Insurance Company	Company Address
Policy Number	Monthly Premium

Signature

I declare under penalty of perjury that each and every statement on this form is true, correct, and complete

Itemization Form

Date of Service	Description of Service	Amount Claimed
	TOTAL:	