



BASIC INFORMATION

**Please note that this request must be submitted by a first level supervisor or an H/R Supervisor.*

Today's date: _____ **Department / Agency:** _____

Name of Individual in need: _____

Title/Position of individual in need: _____

Email address: _____ **Date of birth:** _____ **Years of service:** _____

Beneficiary Name: _____

Home Phone: _____ **Mobile:** _____ **Other:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Is individual a full-time paid employee? YES/NO

Is individual sworn or certified? YES/NO

Reason for special need:

BENEFICIARY INFORMATION (IF DIFFERENT THAN ABOVE)

Beneficiary Name: _____

Home Phone: _____ **Mobile:** _____ **Other:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Make Benefit Check To: _____ Relationship to Injured: _____

Where Shall Payment Be Delivered? _____

How Many Dependents (Other Than Spouse): _____

Name, Sex, and Date of Birth of Dependents:

**This information is used internally to provide opportunities to dependents such as: summer camp, holiday gift giving, scholarship opportunities, etc.*

1. Name: _____ Sex: ___ DOB: _____

2. Name: _____ Sex: ___ DOB: _____

3. Name: _____ Sex: ___ DOB: _____

4. Name: _____ Sex: ___ DOB: _____

5. Name: _____ Sex: ___ DOB: _____

**if needed please continue information on separate document*

INFORMATION PROVIDED BY

**Must be submitted by a first level supervisor or an H/R Supervisor.*

Your Name: _____ Title: _____

Department/Agency: _____

Agency Address: _____ City/St/Zip: _____

Office Phone: _____ Mobile: _____ Other: _____

Email: _____

Your Signature: _____ Date: _____

To submit form by email, send to benefits@100club.org | To submit by fax, use (602) 242-1715

TO BE COMPLETED BY AUTHORIZED 100 CLUB PERSONNEL

Verified/Approved: _____ Date: _____ Data ID: _____ Payment ID: _____

Posted: _____ Date: _____ Check #: _____ Amount: _____

Denied: _____ Date: _____