THIN BLUE LINE OF MICHIGAN

Membership/Donation Form

Name: (printed) _____

Home Address: _____

City: _____ State: MI Zip: _____

Phone: _____

Email: _____

Social Security No: _____ Police Officer:_____Dispatcher/Clerk:_____

Command Officer: _____ Firefighter:_____ Other:_____

Department: _____

ENROLLEE COVERAGE

Name: _____

Age: _____ D.O.B.:_____/_____/_____

Spouse name: _____

Age: _____ D.O.B.:_____/_____/_____

Enrollee's Beneficiary: _____

Relationship: _____

I understand and agree that the insurance applied for shall become effective 30 days following the first payment.

Signature of enrollee: _____

Date: _____

New Enrollee: ☐ Updating Information: ☐