

I acknowledge and understand that I am not required but at my option and expense may consult and or retain legal counsel in regard to this Application and my claim for disability retirement benefits. I will retain legal counsel or my attorney must promptly file a written notice of representation if I

Member/Applicant's initials

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Member/Applicant's initials

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Member/Applicant's initials

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Member/Applicant's initials

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Member/Applicant's Signature

Date Signed

Printed Name

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Last First Middle

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Number Street Unit/Apt City State Zip Code

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~~(509) 557-8888~~

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B Applicant's Signature

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Date Signed