SAN FRANCISCO CITY AND COUNTY RETIREE HEALTH CARE TRUST FUND
NOMINATION FORM

We, the undersigned members of the San Francisco City and County Health Service System, hereby nominate:

NAME _____

DEPARTMENT/RETIREE _____

for member of the Retiree Health Care Trust Fund Board for the full term June 12, 2019 to June 11, 2024.

In witness whereof, we have herewith signed our names and places of employment or retiree status.

NOTE:

1.	Nomination Form must be filed with the Retiree Health Care Trust Fund no later than 5:00 p.m. Friday, February 25, 2019 (address shown below).
2.	Nominators signing on the attached form must be members, active or retired, of the San Francisco City and County Health Services System.
3.	Twenty (20) valid signatures are required. (Twenty-five (25) spaces are provided in the event some of the signatures are disqualified.)
4.	The member's DSW number or last four (4) numbers of the member's Social Security Number must be entered. San Francisco City and County Health Services System staff must verify the person signing is a member of the Health Services System.

SAN FRANCISCO CITY AND COUNTY RETIREE HEALTH CARE TRUST FUND
1145 MARKET STREET, 7TH FLOOR
SAN FRANCISCO, CA 94103
ATTN: RETIREE HEALTH CARE TRUST FUND BOARD

SAN FRANCISCO CITY AND COUNTY RETIREE HEALTH FUND TRUST NOMINATION FORM

SIGNATURE	PRINTED NAME	DSW NUMBER OR SOCIAL SECURITY NUMBER (LAST FOUR NUMBERS ONLY)	DEPARTMENT/RETIREE*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19			
20.			
21.			
22.			
23.			
24.			
25.			

*If you are an ACTIVE member, indicate the name of your Department. If you are a RETIRED member, indicate "Retiree" under Column 4, DEPARTMENT/RETIREE

ACCEPTANCE BY NOMINEE:

_____ hereby accept the foregoing nomination for Retiree Health Fund Trust Board and if elected agree to serve.
(Printed Name)

Signed: _____ Date: _____

Department/Retiree: _____