1199SEIU Health Care Employees Pension Fund
PO Box 975, New York, NY 10108-0975 • Tel: (646) 473-8666 • Outside NYC: (800) 575-7771 • Fax: (646) 473-8747 • www.1199SEIUBenefits.org • @1199SEIUBenefits

Application for Normal or Early Pension

Follow these instructions carefully and completely to avoid delays in processing your pension benefit. If you wish to meet with a Pension Counselor who can assist you with completing the application and the retirement process, contact the Pension Fund at (646) 473-8666 or (800) 575-7771.

1. Read each section and answer each question that applies to you. All requested information is needed to process your application and determine the amount of benefits for which you may qualify. If a section or question does not apply to you, mark it "N/A" for "Not Applicable." Print clearly in blue or black ink. If completing online, type in your information.

2. Documents required:

   Your pension may be **DELAYED** if you do not submit clear copies of the following documents with your application. If your documents are in a language other than English, you must bring the originals and notarized translated copies.

   a. Citizenship/Proof of Age: Proof of citizenship/age for you, your spouse and/or your beneficiary can be satisfied by submitting one of the following: birth certificate, driver license, naturalization papers, passport or resident alien card
   b. Government-issued marriage certificate, if married
   c. Death certificate for spouse, if applicable
   d. Divorce judgment, if divorced
   e. Affidavit for Unlocatable Spouse, if separated and you are unaware of your spouse's whereabouts (affidavit is attached to this application)
   f. Your most recent pay stub
   g. Social Security cards for you, your spouse and/or your beneficiary
   h. Voided check or copy of bank statement, for enrolling in direct deposit
   i. Medicare card with Medicare Beneficiary Identifier (MBI) number, if you are enrolled in Medicare

3. Remember to **SIGN AND DATE** the completed application or it will not be valid.

4. Keep a copy of the completed application for your records.

5. **DO NOT** submit this application more than six (6) months before your intended retirement date. Your application is only valid for six (6) months after it is received.

6. When you meet eligibility requirements, your pension benefit will be effective: a) the first of the month following your last day of work; b) the first of the month following the date you filed your completed pension application; c) the date you requested on your application; **or** d) if disabled, the first of the month after last disability payment is received from the Benefit Fund, whichever is later.

Mail or fax the completed application and clear copies of required documents to:
1199SEIU Health Care Employees Pension Fund
PO Box 975, New York, NY 10108-0975
Fax: (646) 473-8747

A. Personal Data

MEMBER'S FULL NAME (FIRST AND LAST NAME) | MEMBER ID # OR SOCIAL SECURITY #

Address instructions:

PERMANENT ADDRESS: This is your home address (the place where you live). **DO NOT LIST A PO BOX.**

MAILING ADDRESS: Fill in this line if you want your mail sent to a location other than your permanent address. **YOU CAN LIST A PO BOX.** If you prefer to receive mail at your permanent address, leave this line blank.

PERMANENT ADDRESS *(do not list a PO Box)* | CITY | STATE | ZIP CODE

MAILING ADDRESS *(you can list a PO Box)* | CITY | STATE | ZIP CODE

DATE OF BIRTH (MM/DD/YYYY) | HOME PHONE | CELL PHONE

EMAIL ADDRESS

COUNTRIES OF CITIZENSHIP *(see #2a on page 1 for more information)*

Gender ***(choose one):*** ☐ Male ☐ Female

Do you have End-stage Renal Disease (ESRD)? ☐ No ☐ Yes

If "Yes," provide a clear copy of your ESRD Medical Evidence Report to the Benefit Funds' Eligibility Department. Fax it to (646) 473-6829 or mail it to 1199SEIU Benefit Funds, PO Box 1144, New York, NY 10108-1144.

Current marital status ***(choose one):*** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SPOUSE'S FULL NAME (FIRST AND LAST NAME) | SPOUSE'S SOCIAL SECURITY #

SPOUSE'S DATE OF BIRTH (MM/DD/YYYY) | IF MARRIED, DATE OF MARRIAGE (MM/DD/YYYY)

IF DIVORCED, DATE OF DIVORCE (MM/DD/YYYY) | IF WIDOWED, DATE OF DEATH (MM/DD/YYYY)

If married but separated, insert the last known address and phone numbers of your spouse:

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE

I request my pension benefit to begin on the first day of _____ (MONTH), 20____ (YEAR)

Indicate your reason for retirement: _____

MEMBER ID # OR SOCIAL SECURITY #

B. Employment History

Current or Last Employment Information – List Only Your 1199SEIU Job

CURRENT OR LAST 1199SEIU EMPLOYER (INSTITUTION/FACILITY NAME)

ADDRESS | CITY | STATE | ZIP CODE

WORK PHONE | CURRENT OR LAST JOB TITLE

DATE YOU STARTED AT THIS JOB (MM/DD/YYYY) | DATE YOU WILL LEAVE WORK / DATE YOU LEFT WORK (MM/DD/YYYY)

ANNUAL BASE GROSS SALARY | OR | HOURS WORKED PER WEEK | AND | HOURLY RATE

Did you work in the same position from the date you started with this employer? ☐ Yes ☐ No

If "No," indicate the month and year that you started with this employer, and the job title that you started with:

Have you ever had any breaks in service? ☐ No ☐ Yes

If "Yes," indicate below which breaks in service you have taken, and the dates of these breaks. Provide clear copies of any documentation to support these breaks in service.

Breaks in Service	From (MM/DD/YYYY)	To (MM/DD/YYYY)
Disability Leave		
FMLA Leave		
Maternity/Paternity Leave		
Paid Family Leave (PFL)		
Personal Leave		
Qualified Military Leave		
Training and Upgrading Leave		
Workers' Compensation Leave		

MEMBER ID # OR SOCIAL SECURITY #

Additional Employment Information

Fill out this section if: a) you currently work for a second employer in an 1199SEIU position; b) in the past, you worked for other employers in an 1199SEIU position; **and/or** c) in the past, you worked in the healthcare or human services industry or a related industry. You can list up to four (4) employers.

1. EMPLOYER (INSTITUTION/FACILITY NAME) JOB TITLE

   ADDRESS CITY STATE ZIP CODE

   DATE STARTED (MM/DD/YYYY) DATE ENDED (MM/DD/YYYY)

2. EMPLOYER (INSTITUTION/FACILITY NAME) JOB TITLE

   ADDRESS CITY STATE ZIP CODE

   DATE STARTED (MM/DD/YYYY) DATE ENDED (MM/DD/YYYY)

3. EMPLOYER (INSTITUTION/FACILITY NAME) JOB TITLE

   ADDRESS CITY STATE ZIP CODE

   DATE STARTED (MM/DD/YYYY) DATE ENDED (MM/DD/YYYY)

4. EMPLOYER (INSTITUTION/FACILITY NAME) JOB TITLE

   ADDRESS CITY STATE ZIP CODE

   DATE STARTED (MM/DD/YYYY) DATE ENDED (MM/DD/YYYY)

Prior Pension Plan Information

Have you ever been covered by any of the following pension plans? ☐ No ☐ Yes

- Health Services Retirement Plan
- Hospital League Pension Plan
- Long Island Jewish Medical Center Tax-sheltered Annuity Plan (employer now known as Northwell Health)
- Brookdale Hospital and Medical Center Salaried Employees Pension Plan
- Yeshiva University Retirement Income Plan
- Mount Sinai Hospital and School of Medicine Tax-sheltered Annuity Plan
- 1199SEIU Greater New York Pension Fund Plan
- SEIU Affiliates' Plan for Employees
- SEIU Staff Plan for Employees
- Local 721SEIU Plan (LPN)

MEMBER ID # OR SOCIAL SECURITY #

If "Yes," insert the names of the pension plans and the dates of participation:

Pension Plan	From (MM/DD/YYYY)	To (MM/DD/YYYY)

C. Employment after Retirement

The Pension Fund does not allow you to collect your pension benefit (unless you are older than 70½) while you are still working in Disqualifying Employment, as defined below.

Disqualifying Employment

For your employment to be considered "Disqualifying Employment," it must meet **ALL** of the following requirements:

- You work more than 40 hours per month;
- You work in the healthcare or human services industry or a related industry (including, but not limited to, hospitals, nursing and convalescent homes, drugstores, laboratories, medical schools and universities);
- You work using skills applicable to your previous employment in the healthcare or human services industry or a related industry; **AND**
- You work in a state in which contributions to the Pension Fund were made or were required to be made.

I understand that I am not allowed to receive pension payments while I am working in Disqualifying Employment (as defined above). I certify that I am not currently working in Disqualifying Employment. If at any time while I am receiving pension payments I become engaged in Disqualifying Employment, I will notify the Pension Fund.

Note: When you apply for a Normal Retirement Pension or an Early Retirement Pension, you must select one of the pension options provided in the Plan and Summary Plan Description (SPD). If a married participant dies prior to collecting his or her pension benefit, the spouse may be entitled to a qualified pre-retirement spouse survivor benefit, in accordance with the provisions of the Plan and SPD.

READ BELOW. PRINT OUT THE COMPLETED APPLICATION, THEN SIGN AND DATE IT.
THE APPLICATION CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE.

D. Authorization

I understand that in order to process my pension application, the Pension Fund may need to obtain additional information from me (or from a Contributing Employer or the Social Security Administration). In this event, I understand that it may take longer than 90 days for the Fund to make a determination on my claim for benefits. By signing this application, I hereby consent to the extension of any time periods in the Plan for making benefit determinations until the Fund receives all the necessary information. I certify that the information provided in this application is correct.

X _____

BENEFICIARY APPLICANT'S SIGNATURE **(REQUIRED)** DATE (MM/DD/YYYY) **(REQUIRED)**

Mail or fax the completed application **AND** clear copies of required documents to:

1199SEIU Health Care Employees Pension Fund
PO Box 975, New York, NY 10108-0975
Fax: (646) 473-8747

AFFIDAVIT FOR UNLOCATABLE SPOUSE

Complete this form if you are separated from your spouse and are unaware of his or her whereabouts.
(Please print clearly in blue or black ink. If completing online, please type in your information.)

Member ID # or Social Security #: _____

I, _____ , being duly sworn, depose and say: I am an applicant for a pension from
BENEFICIARY APPLICANT'S NAME

the 1199SEIU Health Care Employees Pension Fund. I was married to _____ ,
SPOUSE'S NAME

on _____ , in _____ .
DATE (MM/DD/YYYY) CITY, STATE, COUNTRY

In accordance with federal law and under the Plan, I understand that I am required to have the consent of my spouse for the type of pension payment I have selected.

My spouse and I have not been living together since _____ , and I have not seen or heard from my
DATE (MM/DD/YYYY)

spouse since _____, and I do not know whether my spouse is alive or dead.
DATE (MM/DD/YYYY)

My spouse's Social Security number is: _____ .
SPOUSE'S SOCIAL SECURITY NUMBER

In order to obtain the consent of my spouse for the pension option that I desire, I have written, by both certified and regular mail, to each of the following individuals:

1. I have written to the last address of my spouse known to me, at:

   _____ .
   SPOUSE'S ADDRESS

2. I have written to _____ , a relative of my spouse,
   RELATIVE'S NAME

   at: _____ .
   RELATIVE'S ADDRESS

3. I have written to _____ , the child(ren) of our marriage,
   CHILD(REN)'S NAME(S)

   at: _____ .
   CHILD(REN)'S ADDRESS(ES)

4. I have taken the following additional steps to locate and obtain the consent of my spouse:

   _____

   _____

Member ID # or Social Security #: _____

I submit this affidavit in order to demonstrate to the 1199SEIU Health Care Employees Pension Fund that the consent of my spouse cannot be obtained, and that the Plan should not be liable for payment to my spouse if my spouse should make a claim against the Pension Fund. Accordingly, I am requesting that pension payments be made to me in the manner selected on the approved form, until or unless my spouse makes a claim against the Pension Fund during my lifetime.

_____

BENEFICIARY APPLICANT'S SIGNATURE

THIS DOCUMENT MUST BE NOTARIZED. PLEASE HAVE THE SECTION BELOW COMPLETED, SIGNED AND SEALED BY A NOTARY PUBLIC.

On the _____ day of _____ , 20 _____, before me came

_____ , to me known and known to me to be the person

described above who executed the foregoing statement and (s)he duly acknowledged to me that (s)he executed the same.

[NOTARY SEAL]

My commission expires:

_____ , 20_____

_____

COUNTY STATE

_____

NOTARY SIGNATURE