PLEASE PRINT CLEARLY IN BLUE/BLACK INK

1199SEIU Health Care Employees Pension Fund
330 West 42nd Street • New York, NY 10036-6977 • www.1199SEIUBenefits.org • Tel (646) 473-8666
Outside NYC Area Codes: (800) 892-2557 • Westchester & Upstate Counties: (877) 557-1199

APPLICATION FOR NORMAL, EARLY PENSION, OR DISABILITY

FORMER 144 HOSPITAL DIVISION

Instructions

Follow these instructions carefully and completely to avoid delays in processing your benefit. We encourage you to meet with a Pension Counselor who can assist you with completing the application and the retirement process. Please contact the Pension Fund at (646) 473-8666 to set up an appointment.

1. Read and answer each section or question that applies to you. All requested information is needed to process your application and determine the maximum amount of service and benefits for which you may qualify. If a section or question does not apply to you, please mark it "N/A" for "Not Applicable."

2. Documents Required:
   Note: Your pension may be **delayed** if you do not submit copies of the following documents with your application:

   a. **Member**: Proof of Age for you and your spouse (if married): Birth Certificate, Naturalization Papers, Passport, or other official documents. (No Driver's License accepted)
   b. **Spouse or beneficiary**: if you choose an option that provides benefits - Proof of Age, Birth Certificate, Naturalization Papers, Passport, or other official documents
   c. Marriage Certificate, if married
   d. Death Certificate for spouse, if applicable
   e. Divorce Judgment, if divorced
   f. Recent pay stub
   g. Social Security Card for you, spouse or beneficiary
   h. Written correspondence from the Human Resources department of your current or last employer, documenting your last day worked
   i. Copy of your Notice of Disability Award from the Social Security Administration, if applying for a Disability Pension

3. **Remember to sign and date this application or it will not be valid.**

4. Keep a copy of this application for your records.

5. Your application is only valid for 6 months after the date it is received, so please do not submit until you are ready to retire.

6. Your pension benefit will be effective the month following your last day of work or the filing of the application or on the date you request on your application, whichever is later.

7. If you are separated and you do not know the whereabouts of your spouse, please complete the enclosed Unlocatable Spouse Affidavit. To obtain your spouse's consent to the form of payment that you desire to elect you must contact your spouse in writing. The letter(s) must be sent to your spouse's last known address. If your spouse's consent cannot be obtained and you receive the returned unopened envelope, then they must be returned to the Fund as proof of your efforts to locate your spouse.

8. If you left covered employment or worked for other employers in an 1199SEIU, 1115 and/or 144 position, please complete the attached Request for Social Security Earnings Information form.

PLEASE MAIL YOUR COMPLETED APPLICATION
(WITH COPIES OF REQUIRED DOCUMENTS) TO:
1199SEIU Health Care Employees Pension Fund
Times Square Station
PO Box 975
New York, NY 10108-0975

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APPLICATION FOR PENSION BENEFITS

FORMER 144 HOSPITAL DIVISION

This application must be completed and submitted to the Pension Fund Office before your intended retirement date.

Are you applying for a: ❑ Normal Retirement Pension ❑ Early Retirement Pension ❑ Disability

A. PERSONAL DATA

Name _____ Social Security # _____
(First) (Middle) (Last)

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Telephone (_____)_____ Date of Birth _____/_____/_____ Sex ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

If married, spouse's name _____ Date of Marriage _____/_____/_____

Spouse's Social Security # _____ Spouse's Date of Birth _____/_____/_____

If divorced, date of divorce _____/_____/_____ If widowed, spouse's date of death _____/_____/_____

If married but separated, last-known address & phone # of spouse: Telephone (_____) _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

B. EMPLOYMENT HISTORY

Where employed (or last employed) in an 1199SEIU, 1115, 758 or 144 position:

Institution _____ Address _____

City _____ State _____ Zip Code _____

Job Title _____ Employer Telephone (____) _____

Date Started _____/_____/_____ Date you will leave (left) work _____/_____/_____
Month Day Year Month Day Year

Reason for retirement _____

Hours worked per week at time of retirement _____

I request my pension to begin on the first day of _____, 20_____
Month Year

Have there ever been any breaks in service? ❑ Yes ❑ No

If yes, please indicate reason for Break:

	From	To
Personal Leave		
Maternity/Paternity Leave		
Disability		
FMLA Leave		
Worker's Compensation.		
Qualified Military Leave		

Provide any documentation to support these breaks in service.

If you have worked for other employers in an 1199SEIU, 1115, 758 and or 144 position, or if you have worked in the healthcare or human industry, please provide the information requested below:

Name of Employer (s)	City, State	Job Title	Mo. Yr. Started/ Mo. Yr. Left

RULES AND REQUIREMENTS

A. To assure prompt processing of your entitlement for pension benefit, this application should be completed and submitted to the Pension Fund Office before your retirement. You must complete the above information, which indicates when you want your monthly pension payments to begin. If eligible, your pension benefits will begin the month following the date that you filed the application and submitted all the required documentation.

B. If you are married, and you and your spouse choose the Joint & 50 % Survivor Option, you must promptly submit proof of your spouse's date of birth to the Pension Fund Office.

C. If you are married, and you and your spouse choose the Lifetime Pension with 60-month Guaranteed Option or the Joint and 75% Survivor Option, the Spousal Waiver Agreement in this application must be completed and signed by your spouse.

D. You may change your option election and beneficiary at any time before your pension payments begin. To change the beneficiary, you must complete a new designated beneficiary form for the 60-month guaranteed pension option. If your spouse has retained the right to consent to subsequent changes in the beneficiary, you will also need to complete and sign a new spousal waiver form to make this change.

E. If you have been awarded a Social Security Disability award and have at least 15 pension credits, you may be eligible for Disability Pension Benefits.

C. IF YOU BECOME DISABLED

You may qualify for a Disability Pension Benefit if you:

- Are approved for Social Security Disability Benefits, and
- Are both totally and permanently disabled, and
- Have a disability that has continued for a period of 6 months, and
- Have at least 15 Pension Credits, and
- Be at least age 50, but younger than age 63, and
- Have worked in Covered Employment for an employer contributing to the Pension Fund for at least 436 hours in the 24 months before you became disabled, and
- Have filed an application for a Disability Pension with the Pension Fund Office within the later of: 18 months after the date your disability commenced, or within 6 months after receiving a determination of disability from Social Security Administration.

A Disability Pension Benefit is not automatic. You must apply for this benefit with the Pension Fund.
If you are eligible, you may apply for an Early Retirement Pension while you are waiting for approval for a Social Security Disability Benefit Award. Your Early Retirement Pension will be converted to a Disability Pension Benefit. Depending on when you filed your pension application, the benefit will be retroactive to the 7th month of disability, provided you have filed a completed pension application along with all the required documentation within 18 months of the date your disability commenced *or* within 6 months of the date of your Social Security Disability Award. Payments will begin upon approval of your application, with the first payment containing the retroactive payments. If you fail to file your application within that time period, the first monthly payment will start no sooner than the month following the date on which your application is finalized. There will be no retroactive payments.

Your Disability Pension Benefit will be paid in an amount equal to the (REGULAR OR DEFERRED PENSION) to which you would have been entitled at age 63.

You will continue to receive the Disability Pension Benefit as long as you continue to qualify for Social Security Disability Benefit payments. If your Social Security Disability Benefit is discontinued or ends, you MUST immediately inform the Pension Fund.

D. DESIGNATED BENEFICIARY FORM FOR DEATH BENEFIT OF $1,000.00

This person is the: ❑ Primary ❑ Secondary

1. Name of Beneficiary: _____
   First Name Last Name
   Relationship: _____ Date of Birth _____/_____/_____
   Social Security #: _____ Telephone #: ( ) _____
   Street Address: _____
   City: _____ State: _____ Zip Code: _____

This person is the: ❑ Primary ❑ Secondary

2. Name of Beneficiary: _____
   First Name Last Name
   Relationship: _____ Date of Birth _____/_____/_____
   Social Security #: _____ Telephone #: ( ) _____
   Street Address: _____
   City: _____ State: _____ Zip Code: _____

Select the beneficiary option of your choice:

❑ Share the Benefit Equally between the 2 beneficiaries listed

❑ Pay the Benefit only to ONE Primary Beneficiary. The Benefit will only be paid to the Secondary Beneficiary if the Primary Beneficiary is deceased.

Member Name (Print) _____ Member SSN _____

Member Signature _____ Date _____

E. AFFIDAVIT FOR NAME CHANGE

(Complete this form if your name has changed)

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

_____, being duly sworn, deposes and says:
FULL NAME

I make this affidavit in connection with my pension application for benefits from the 1199SEIU Health Care Employees Pension Fund.

I am known to the Pension Fund as _____
FULL NAME

I have also used the name of _____
FULL NAME

My Social Security number is _____

I am one and the same person and make this affidavit to induce the Trustees to act favorably on my application for Pension Benefits.

_____
MEMBER SIGNATURE

Sworn to me this _____ _____, 20 _____
Day Month Year

_____
NOTARY PUBLIC

F. EMPLOYMENT AFTER RETIREMENT

I understand that if I return to any type of employment specified below, my pension benefits will be suspended for the duration of such **Totally Disqualifying Employment.** Totally Disqualifying Employment means employment that is: (1) in any industry covered by the Plan, or (2) in the geographic area covered by the Plan, or (3) in any occupation in which you worked while covered by the Plan. However, if you worked in a skilled position, only work done after retirement that involves that skill or craft will cause your benefits to be suspended.

If you retire before you reach Normal Retirement Age, your benefits will be suspended for any month or months in which you undertake any Totally Disqualifying Employment as described above. If you retire after reaching Normal Retirement Age, your benefits will be suspended for any months in which you work over forty (40) hours, subject to the rules governing payments for working members after attaining age 70 ½.

PENSIONER MUST SIGN HERE AFTER COMPLETING THIS APPLICATION

Member Signature _____ **Date** _____

AFFIDAVIT FOR UNLOCATABLE SPOUSE

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, _____, being duly sworn, deposes and says, I am an applicant for
NAME OF APPLICANT

a pension from the 1199SEIU Health Care Employees Pension Fund. I was married to _____

_____, on _____, in _____
NAME OF SPOUSE

We have not been living together since _____, and I have not seen or heard from my spouse
DATE
since _____ and I do not know whether my spouse is alive or dead.
DATE

In accordance with Federal law and under the Plan, I am required to have the consent of my spouse for the type of pension payment I have selected. As specified above, I have not seen or heard from my spouse since _____.
DATE

In order to obtain the consent of my spouse to the pension option, which I desire, I have made the following efforts:

1. I have written to the last address of my spouse known to me:
   _____
   both certified and regular mail. The returned unopened envelopes are attached.
   Telephone: ( ) _____

2. I have written to the last known employer of my spouse at:
   _____
   both certified and regular mail. The returned unopened envelopes are attached.
   Telephone: ( ) _____

3. I have written to _____, a relative of my spouse at:
   _____
   both certified and regular mail. The returned unopened envelopes are attached.
   Telephone: ( ) _____

4. I have written to _____, the legal representative of my spouse at:
   _____
   both certified and regular mail. The returned unopened envelopes are attached.
   Telephone: ( ) _____

5. I have written to children of the marriage at:
   _____
   both certified and regular mail. The returned unopened envelopes are attached.
   Telephone: ( ) _____

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

_____

_____

_____

_____

The results are attached.

I submit this affidavit in order to demonstrate to the 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 claim against the Pension Fund. Accordingly, I am requesting that pension payments be made to me in the manner selected on the approved form, unless and until my spouse makes a claim against the Pension Fund during my lifetime.

_____

YOUR SIGNATURE

Sworn to me this _____ _____, 20____

Day Month Year

_____

NOTARY PUBLIC

List of Enclosures: _____

_____

_____

_____

_____

_____

OFFICE USE ONLY

Date Received __/__/___ Interview Date __/__/___ Interviewed by _____

Comments

_____

_____

_____

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name _____ Social Security Number _____

   Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

   ☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

   _____

   _____

   ☐ **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

   Do you want us to certify the information? ☐ Yes ☐ No

   If yes, enter $15.00 . . . . . B. $ _____

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

   SIGN your name here (Do not print) > _____ Date _____

   Daytime Phone Number _____ _____ (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name _____ Address _____

   City, State & Zip Code _____

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore Maryland 21290-0300