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 PRINT CLEARLY IN BLUE/BLACK INK
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 ______________________________________________ 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:

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<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>Personal Leave</td>
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<tr>
<td>Maternity/Paternity Leave</td>
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<tr>
<td>Disability</td>
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<td>FMLA Leave</td>
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<td>Worker’s Compensation.</td>
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<td>Qualified Military Leave</td>
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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:

<table>
<thead>
<tr>
<th>Name of Employer(s)</th>
<th>City, State</th>
<th>Job Title</th>
<th>Mo. Yr. Started/Mo. Yr. Left</th>
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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

) ss.

_______________________________________________________, 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  )
COUNTY OF NEW YORK  ) ss.

I, __________________________, being duly sworn, deposes and says, I am an applicant for 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 since __________________________ and I do not know whether my spouse is alive or dead.
DATE
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 For the period(s)/year(s): ____________________________

(If you check this block, tell us below why you need this information.)

☐ Certified Total Earnings For Each Year. For the year(s): ____________________________

(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)

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 payable 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 ____________________________ Date ____________________________

(Do not print) 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: Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

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

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