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 or Early Pension

Instructions:
Follow these instructions carefully and completely to avoid delays in processing your benefit. If you wish to meet with a Retirement Counselor who can assist you with completing the application and the retirement process, please contact the Fund at (646) 473-8666.

Please Print Clearly in Black or Blue Ink

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. For your spouse or beneficiary, if you choose a Joint or Survivor Pension Option: 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.
3. **Remember to sign and date this application at the bottom of Section D, 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
PO Box 975
New York, NY 10108-0975

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 or Early Pension

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

(Please Print Clearly in Black or Blue Ink)

A. Personal Data

Member ID or Social Security #: _____

Member's Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____ Date of Birth: _____/_____/_____ (Month/Day/Year) Sex: ☐ M ☐ F

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

1. If married, spouse's full name: _____

   Spouse's Social Security #: _____ - _____ - _____

   Spouse's Date of Birth: _____/_____/_____ (Month/Day/Year) Date of Marriage: _____/_____/_____ (Month/Day/Year)

2. If divorced, date of divorce: _____/_____/_____ (Month/Day/Year)

3. If widowed, date of spouse's death: _____/_____/_____ (Month/Day/Year)

4. If married but separated, last known address of spouse:

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Telephone: (_____) _____

I request my Pension Benefit to begin on the first day of _____, 20_____.

B. Employment History

Current Employment Information

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

Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Job Title: _____

Date Started: _____/_____/_____ (Month/Day/Year) Date You Will Leave (Left) Work: _____/_____/_____ (Month/Day/Year)

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

If "No" please indicate what month, year and job title: Month/Year _____/_____

Job Title: _____

Current/Last Base Gross Salary $_____ or hours worked per week _____

Current Hourly Rate $_____

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	_____/_____/_____	_____/_____/_____
Workers' Compensation	_____/_____/_____	_____/_____/_____
Qualified Military Leave	_____/_____/_____	_____/_____/_____
Training & Upgrading Leave	_____/_____/_____	_____/_____/_____

Provide any documentation to support these breaks in service.

Reason for Retirement: _____

Prior Employment Information

If you have worked for other employers in an 1199SEIU, 115 and/or 144 position, or if you have worked in the healthcare or human service industry, please provide this information:

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

Prior Pension Plan Information

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

(1) Health Service Retirement Plan
(2) Hospital League Pension Plan
(3) Long Island Jewish Medical Center Tax Shelter Annuity
(4) Yeshiva University Retirement Income Plan
(5) Mt. Sinai Hospital Employees Retirement Income Plan
(6) 1199SEIU GNY Pension Fund
(7) SEIU Affiliates' Plan for Employees
(8) SEIU Staff Plan for Employees
(9) Local 721 SEIU (LPN)

If Yes, complete the date of enrollment in the applicable Pension Plan(s) listed below:

Pension Plan	From	To
	_____/_____/_____	_____/_____/_____
	_____/_____/_____	_____/_____/_____
	_____/_____/_____	_____/_____/_____
	_____/_____/_____	_____/_____/_____

C. Employment After Retirement

The Pension Fund does not allow you to collect your retirement benefit (unless you are over 70½) while you are still working in "Related Employment," as defined below.

Related Employment

For your employment to be considered Related Employment, it must meet **all** of the following requirements:

1. You work for more than 40 hours per month.
2. You are working in the healthcare or human service industry or a related industry (including hospitals, nursing and convalescent homes, drugstores, laboratories, medical schools and universities).
3. You work utilizing skills applicable to your previous employment in the healthcare or human service or related industry.
4. You work in a state in which contributions to the Pension Fund were made or required to be made.

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

When you apply for a Normal Retirement Pension (at age 65), or an Early Retirement Pension, you must select any one of the retirement options provided in the Plan and SPD. Should a married participant die prior to the normal retirement age (65), the spouse may be entitled to a qualified pre-retirement spouse survivor benefit in accordance with the provisions of the Plan and SPD.

D. Social Security Authorization

I understand that in order to process my pension application, the Pension Fund may need to get additional information from me (or from a Contributing Employer or from Social Security). In that event, I understand that it will take longer than 90 days for the Pension 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.

Pensioner must sign here after completing this application.

Your Signature **X** _____ Date: _____

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 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

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

_____
Your Signature

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

_____
Notary Public

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
Date
spouse 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: _____

   _____

   by 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: _____

   _____

   by both certified and regular mail. The returned unopened envelopes are attached.

   Telephone: (_____) _____

3. I have written to _____, a relative of my spouse, at:

   _____

   by both certified and regular mail. The returned unopened envelopes are attached.

   Telephone: (_____) _____

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

   Telephone: (_____) _____

5. I have written to children of the marriage at: _____
by 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_____
Month Day Year

_____
Notary Public

List of Enclosures: _____

_____

_____

_____

Office Use Only

Date Received: _____/_____/_____ Interview Date: _____/_____/_____
Month Day Year Month Day Year

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 1199SEIU Health Care Employee Pension Fund Address 330 West 42nd Street

   City, State & Zip Code New York, NY 10036-6977

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

Form **SSA-7050-F4** (01-2004) EF (09-2008)