PLEASE PRINT CLEARLY IN BLUE OR 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 DISABILITY PENSION BENEFIT

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 discuss the retirement process, please contact the Fund at (646) 473-8666.

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: Birth Certificate, Naturalization Papers, Passport, or other official documents. (No Driver's License accepted)
   b. Recent pay stub
   c. Social Security Card

3. **Remember to sign and date this application at the bottom of Section C & Section D or it will not be valid.**

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

5. 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.

6. You will not automatically get a Disability Pension. You must meet the requirements in the Plan to be entitled to Disability through SSA.

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 DISABILITY PENSION BENEFIT

Please complete all items on this form (please print clearly in ink).

A. PERSONAL DATA

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

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

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

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

1. If married, spouse's name _____
(First) (Middle) (Last)

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

Date of Marriage ___/___/___

2. If divorced, date of divorce ___/___/___

3. If widowed, date of death ___/___/___

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

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Telephone ( ) _____

I request my Disability Pension Benefit to begin on the first day of _____, 20_____
Month Year

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

Reason for Retirement: _____

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.

Prior Employment Information

If you have worked for other employers in an 1199SEIU, 1115 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 listed? ❑ 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 Retirement Income Plan Employees
(6) 1199SEIU GNY Pension Fund
(7) SEIU Affiliates' Plan for Employees
(8) SEIU Staff Plan for Employees
(9) Local 721 SEIU (LPN)

a. If Yes, complete the date of enrollment in the applicable Pension Plan listed below

Pension Plan	From	To

C. DISABLING CONDITION

This section must be completed before your disability application can be processed.

Why did you terminate covered employment or Reason for Retirement? _____

_____

What illnesses, injuries or medical conditions limits your ability to work? _____

Date of injury or illness _____, 20_____
Month Year

Date you became unable to work because of your medical condition or injury _____ , 20 _____
Month Year

Where did injury take place? _____

_____

Did you file a claim for compensation and receive Worker's Compensation benefit payments? ❑ Yes ❑ No
If "yes" please provide copies of your worker's compensation award.

Did you apply for Social Security Disability Insurance Benefits? ❑ Yes ❑ No
If "yes" when did you apply for Social Security Disability Insurance Benefits? _____, 20 _____
Month Year

Please provide a copy of your Social Security Disability application and all favorable and non-favorable decisions (if applicable).

I understand that in order to process my disability 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 may take longer than 90 days for the Fund to make a determination on my claim for benefits. I hereby consent to the extension of any time periods in the Plan for making benefit determinations until the Pension Fund receives all the necessary information. I have read Sections C, D, E, and F on the reverse side of this application.

PENSIONER MUST SIGN HERE AFTER COMPLETING THIS APPLICATION

Your Signature _____ Date _____

D. SOCIAL SECURITY AUTHORIZATION

You must sign this authorization so we can verify you are approved to receive Social Security disability benefits.

This is my application for a disability pension. I authorize the Social Security Administration to release information to the 1199SEIU Health Care Employees Pension Fund verifying my Social Security disability benefits.

I understand that the information the Social Security Administration provides may include verification of my Social Security number and any death indication. My consent allows no additional information to be provided from my Social Security records, and the information provided will be used solely for the purpose of determining eligibility to receive a disability pension from the 1199SEIU Health Care Employees Pension Fund.

I also understand that this authorization will remain in effect, on a continuing basis, while I am receiving benefits under the 1199SEIU Health Care Employees Pension Fund, unless and until revoked by me in writing.

Your Signature _____ Date _____

Your Disability Pension Benefit will be paid in an amount equal to the MONTHLY PENSION WITH NO SURVIVOR option.

Your Disability Pension Benefit will usually start as of the effective date of your Social Security Disability payments. But you cannot receive a Disability Pension Benefit until after your weekly disability benefits from the 1199SEIU National Benefit Fund have ended.

Retroactive benefits are not paid for any time earlier than two years before you filed your application for Disability Pension Benefits with the Pension Fund.

You will continue to receive the Disability Pension Benefit up until age 65, as long as you continue to qualify for Social Security Disability payments. If your SSD Benefit ends, you must immediately inform the Pension Fund. **Once you reach age 65, your Disability Pension Benefit will stop and your Pension will be converted to a Normal Retirement Pension and you will have to elect one of the Post Retirement options as is required by the Plan. You will have to complete a pension application form, including spousal consent if applicable.**

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 provision of the Plan and SPD.

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___
Day Month Year

_____
NOTARY PUBLIC

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

Form **SSA-7050-F4** (1-2004) EF (01-2004)

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