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, Early or Disability Pension
144 Hospital Division

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. Notice of Disability Award from the Social Security Administration, if you are applying for a Disability Pension

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; **or** c) the date you requested on your application, whichever is later.

Mail or fax the completed application and clear copies of required documents to:
1199SEIU Health Care Employees Pension Fund for the 144 Hospital Division
PO Box 975, New York, NY 10108-0975
Fax: (646) 473-8747

A. Personal Data

What type of pension are you applying for? ***(choose one):*** ☐ Normal Retirement ☐ Early Retirement ☐ Disability

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

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		
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 the 1199SEIU Greater New York Pension Fund Plan? ☐ No ☐ Yes

If "Yes," indicate date of participation: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

C. If You Become Disabled

You may qualify for a Disability Pension benefit if you meet **all** of the following requirements:

- You are between the ages of 50 and 63;
- You are *both* totally and permanently disabled;
- You have a disability that has continued for a period of six (6) months;
- You have at least 15 Pension Credits;
- You have worked in Covered Employment for an employer contributing to the Pension Fund for at least 436 hours within the 24 months before you became disabled; **and**
- You have filed an application for a Disability Pension with the Pension Fund within the later of: 18 months after the date your disability commenced; or six (6) months after the date you received a Social Security Disability Award entitling you to a Social Security benefit in connection with your retirement, survivors and disability coverage.

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 Award. After approval, 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 seventh (7th) month of disability, provided you have filed a completed pension application along with all required documentation within 18 months of the date your disability commenced or within six (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 to which you would have been entitled to 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. Employment after Retirement

When planning your retirement income, it is important to take into account that as an 1199SEIU retiree, you cannot work more than 40 hours per month in Disqualifying Employment and receive your pension benefit at the same time. The exception to this rule, however, is if you are over age 70 ½, you may do both.

“Disqualifying Employment” means employment that is:

- In any industry covered by the Plan;
- In the geographic area covered by the Plan; and
- In any occupation in which you work while covered by the Plan.

If you retire before you reach Normal Retirement Age, your pension will be suspended for any month or months in which you work in Disqualifying Employment while you are between the ages of 55 and 65. Once you reach age 65, you are subject to the 40-hour rule described above.

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. I understand that I will not accrue Pension Credit for work in Covered Employment while I am receiving a pension benefit during any period before April 1 of the calendar year following the year I turn age 70 ½.

MEMBER ID # OR SOCIAL SECURITY #

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.

E. Designated Beneficiaries for $1,000 Death Benefit

Please designate your beneficiary(ies) below to ensure a payment of a $1,000 upon your death. **You can choose up to two (2) beneficiaries.** The beneficiaries on file at the time of your death is binding in the payment of your benefits. **If the beneficiary is a minor (under age 18),** include the minor's date of birth and the full name of the person who will act as the minor's guardian until the minor reaches age 18.

Your death benefit will be paid first to your primary beneficiary, which you can designate by checking the box marked "primary beneficiary." You **MUST** designate at least one primary beneficiary. If you want two different people to be your primary beneficiary, **EACH** person must be marked as a **"primary beneficiary"** and the benefit will be divided equally between them.

Your secondary beneficiary will receive your death benefit ONLY if your primary beneficiary dies. Choosing a secondary beneficiary is optional; You do not have to choose one if you don't want to. If you do want one, you can designate by checking the box marked **"secondary beneficiary."** Anyone listed as a primary beneficiary **CANNOT** be listed as a secondary beneficiary.

Note: You cannot choose yourself as a beneficiary or guardian.

This person is the: ☐ primary beneficiary ☐ secondary beneficiary

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

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

ADDRESS | CITY | STATE | ZIP CODE

RELATIONSHIP TO MEMBER | IF BENEFICIARY IS UNDER AGE 18, LIST GUARDIAN'S FULL NAME (FIRST AND LAST NAME)

This person is the: ☐ primary beneficiary ☐ secondary beneficiary

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

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

ADDRESS | CITY | STATE | ZIP CODE

RELATIONSHIP TO MEMBER | IF BENEFICIARY IS UNDER AGE 18, LIST GUARDIAN'S FULL NAME (FIRST AND LAST NAME)

MEMBER ID # OR SOCIAL SECURITY #

Select the beneficiary option of your choice ***(choose one):***

☐ Share the benefit equally between the two 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'S FULL NAME (FIRST AND LAST NAME) MEMBER ID # OR SOCIAL SECURITY #

X _____

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

READ SECTIONS F AND G BELOW (YOU MUST SIGN AND DATE SECTION F; COMPLETE SECTION G IF APPLICABLE). PRINT OUT THE COMPLETED APPLICATION, THEN SIGN AND DATE IT. THE APPLICATION CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE.

F. 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 _____

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

_____
MEMBER ID # OR SOCIAL SECURITY #

THE FOLLOWING SECTION MUST BE COMPLETED BY MEMBERS WHO ARE NOT MARRIED. YOU MUST HAVE THIS PAGE NOTARIZED.

G. Authorization of Unmarried Members

This section must be completed by members who are not married.

I, _____ , am the member and herewith certify under penalties
MEMBER'S NAME

of perjury that I am not married. My Member ID # or Social Security # is: _____ .
MEMBER ID # OR SOCIAL SECURITY #

_____
MEMBER'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

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

1199SEIU Health Care Employees Pension Fund for the 144 Hospital Division
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
MEMBER'S NAME

the 1199SEIU Health Care Employees Pension Fund for the 144 Hospital Division.

I was married to _____, on _____ ,
SPOUSE'S NAME DATE (MM/DD/YYYY)

in _____.
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 for the 144 Hospital Division 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.

_____

MEMBER'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