1199SEIU Home 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 36-month Guarantee or 60-month Guarantee Pension

Follow these instructions carefully and completely to avoid delays in processing your pension benefit. **Please note:** Throughout this application, the 1199SEIU member who has died will be referred to as the "member" or "deceased member." As the person who is applying for a survivor's benefit, you will be referred to as the "beneficiary applicant."

1. Read each section and answer each 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, 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 for you and proof of age for you and the deceased member can be satisfied by submitting one of the following: birth certificate, driver license, naturalization papers, passport or resident alien card

   b. Death certificate for the deceased member

   c. Social Security cards for you and the deceased member

   d. Voided check or copy of bank statement, for enrolling in direct deposit

   e. Affidavit for Name Change, if your name has changed (affidavit is attached to this application)

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. Your pension benefit will be effective: a) the first of the month following the member's death; b) the first of the month following the date you filed your completed pension application; **or** c) the month after the deceased member would have been at early retirement age (age 55), whichever is later.

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

A. Personal Data

As the beneficiary applicant, you must fill in ALL of the information in this application. Along with the completed application, you must submit documentary proof of: a) citizenship for yourself; and b) age for yourself and the deceased member. See #2 (documents required) on page 1 for more information.

DECEASED MEMBER'S FULL NAME (FIRST AND LAST NAME)

DECEASED MEMBER'S MEMBER ID # OR SOCIAL SECURITY # | DECEASED MEMBER'S DATE OF DEATH (MM/DD/YYYY)

BENEFICIARY APPLICANT'S FULL NAME (FIRST AND LAST NAME) | BENEFICIARY APPLICANT'S 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.

BENEFICIARY APPLICANT'S PERMANENT ADDRESS ***(do not list a PO Box)*** | CITY | STATE | ZIP CODE

BENEFICIARY APPLICANT'S MAILING ADDRESS ***(you can list a PO Box)*** | CITY | STATE | ZIP CODE

BENEFICIARY APPLICANT'S DATE OF BIRTH (MM/DD/YYYY) | BENEFICIARY APPLICANT'S HOME PHONE | BENEFICIARY APPLICANT'S CELL PHONE

BENEFICIARY APPLICANT'S EMAIL ADDRESS

BENEFICIARY APPLICANT'S COUNTRIES OF CITIZENSHIP ***(see #2a on page 1 for more information)***

Beneficiary applicant's gender: ***(choose one):*** ☐ Male ☐ Female

I request my pension benefit to begin on the first day of _____ , 20_____
MONTH YEAR

BENEFICIARY APPLICANT'S ID # OR SOCIAL SECURITY #

B. Employment History

Please indicate the deceased member's last employment in an 1199SEIU position or in the home care industry.

MEMBER'S LAST EMPLOYER (AGENCY NAME)

ADDRESS | CITY | STATE | ZIP CODE

WORK PHONE | LAST JOB TITLE

DATE MEMBER STARTED AT THIS JOB (MM/DD/YYYY) | DATE MEMBER LAST WORKED AT THIS JOB (MM/DD/YYYY)

Additional Employment Information

Fill out this section if: a) the deceased member's last employment included working for a second employer in an 1199SEIU position; b) in the past, the deceased member worked for other employers in an 1199SEIU position; **and/or** c) in the past, the deceased member worked in the home care industry or a related industry. You can list up to two (2) employers.

1.

MEMBER'S EMPLOYER (AGENCY NAME) | JOB TITLE

ADDRESS | CITY | STATE | ZIP CODE

DATE MEMBER STARTED AT THIS JOB (MM/DD/YYYY) | DATE MEMBER LAST WORKED AT THIS JOB (MM/DD/YYYY)

2.

MEMBER'S EMPLOYER (AGENCY NAME) | JOB TITLE

ADDRESS | CITY | STATE | ZIP CODE

DATE MEMBER STARTED AT THIS JOB (MM/DD/YYYY) | DATE MEMBER LAST WORKED AT THIS JOB (MM/DD/YYYY)

BENEFICIARY APPLICANT'S ID # OR SOCIAL SECURITY #

READ BELOW. PRINT OUT THE COMPLETED APPLICATION, THEN SIGN AND DATE IT.
THE APPLICATION CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE.

C. Authorization

I understand that the earliest my pension payments can begin is: a) the first of the month following the member's death; b) the first of the month following the date I filed my completed pension application; **or** c) the month after the deceased member would have been at early retirement age (age 55), whichever is later. 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 _____

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

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

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PO Box 975, New York, NY 10108-0975
Fax: (646) 473-8747

AFFIDAVIT FOR NAME CHANGE

Complete this form if your name has changed.
(Please print clearly in blue or black ink. If completing online, please type in your information.)

Beneficiary Applicant's ID # or Social Security #: _____

I, _____ , being duly sworn, depose and say: I make this affidavit in connection
BENEFICIARY APPLICANT'S NAME

with my pension application for a survivor's benefit from the 1199SEIU Home Care Employees Pension Fund.

I was known to the Pension Fund as: _____ .
FULL NAME

I have also used the name of: _____ .
FULL NAME

My Social Security number is: _____ .
SOCIAL SECURITY NUMBER

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

_____
BENEFICIARY APPLICANT'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