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 Disability Pension

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 can be satisfied by submitting one of the following: birth certificate, driver license, naturalization papers, passport or resident alien card
   b. Your most recent pay stub
   c. Your Social Security card
   d. Voided check or copy of bank statement, for enrolling in direct deposit
   e. Medicare card with Medicare Beneficiary Identifier (MBI) number, if you are enrolled in Medicare
   f. Notice of Disability Award from the Social Security Administration

3. Remember to **SIGN AND DATE** the completed application at the end of Sections C and D, or it will not be valid.

4. Keep a copy of the completed application for your records.

5. **A Disability Pension benefit is not automatic.** You must meet **ALL** of the requirements in the Plan to be entitled to Disability benefits through the Social Security Administration.

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

A. Personal Data

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

Do you have End-stage Renal Disease (ESRD)? ☐ No ☐ Yes

If "Yes," provide a clear copy of your ESRD Medical Evidence Report to the Benefit Funds' Eligibility Department. Fax it to (646) 473-6829 or mail it to 1199SEIU Benefit Funds, PO Box 1144, New York, NY 10108-1144.

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		
Training and Upgrading 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 any of the following pension plans? ☐ No ☐ Yes

- Health Services Retirement Plan
- Hospital League Pension Plan
- Long Island Jewish Medical Center Tax-sheltered Annuity Plan (employer now known as Northwell Health)
- Brookdale Hospital and Medical Center Salaried Employees Pension Plan
- Yeshiva University Retirement Income Plan
- Mount Sinai Hospital and School of Medicine Tax-sheltered Annuity Plan
- 1199SEIU Greater New York Pension Fund Plan
- SEIU Affiliates' Plan for Employees
- SEIU Staff Plan for Employees
- Local 721SEIU Plan (LPN)

MEMBER ID # OR SOCIAL SECURITY #

If "Yes," insert the names of the pension plans and the dates of participation:

Pension Plan	From (MM/DD/YYYY)	To (MM/DD/YYYY)

C. Disabling Condition

This section must be completed before your Disability Pension application can be processed. Provide a clear copy of your Social Security Disability application and clear copies of all Social Security Disability favorable and non-favorable decision notices.

Date of injury or illness: _____ (MONTH), 20 _____ (YEAR)

Where did the injury or illness take place? _____

What type of injury or illness did you sustain? _____

_____

_____

Why was Covered Employment terminated? _____

_____

_____

Did you file a claim for compensation and receive Workers' Compensation benefit payments? ☐ No ☐ Yes

If "Yes," provide clear copies of your Workers' Compensation award.

Did you apply for Social Security Disability Insurance benefits? ☐ No ☐ Yes

If "Yes," indicate the date that you applied for these benefits: _____ (MONTH), 20 _____ (YEAR)

READ BELOW. PRINT OUT THE COMPLETED APPLICATION, THEN SIGN AND DATE SECTIONS C AND D. THE APPLICATION CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE IN BOTH SECTIONS.

Your Disability Pension benefit will be paid in an amount equal to the Straight Life 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 (2) years before you filed your application for Disability Pension benefits with the 1199SEIU Health Care Employees Pension Fund (the Pension Fund). You will continue to receive the Disability Pension benefit until age 65, 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.

MEMBER ID # OR SOCIAL SECURITY #

Once you reach age 65, your Disability Pension benefit will stop and your Disability 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, including a spousal consent form, if applicable.

Note: When you apply for a Normal Retirement Pension or an Early Retirement Pension, you must select one of pension options provided in the Plan and Summary Plan Description (SPD). If a married participant dies prior to the collecting his or her Normal Retirement Pension, the spouse may be entitled to a qualified pre-retirement spouse survivor benefit, in accordance with the provisions of the Plan and SPD.

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 _____

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

D. Social Security Authorization

You must sign this authorization so the Pension Fund can verify that you have been 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 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 Pension Fund. I also understand that this authorization will remain in effect, on a continuing basis, while I am receiving benefits under the Pension Fund, until or unless revoked by me in writing.

X _____

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

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