



**APPLICATION FOR NORMAL, EARLY PENSION, OR DISABILITY
FORMER 144 HOSPITAL DIVISION**

Instructions

Follow these instructions carefully and completely to avoid delays in processing your benefit. We encourage you to meet with a Pension Counselor who can assist you with completing the application and the retirement process. Please contact the Pension Fund at (646) 473-8666 to set up an appointment.

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. **Spouse or beneficiary:** if you choose an option that provides benefits - 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
 - h. Written correspondence from the Human Resources department of your current or last employer, documenting your last day worked
 - i. Copy of your Notice of Disability Award from the Social Security Administration, if applying for a Disability Pension
3. **Remember to sign and date this application 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
Times Square Station
PO Box 975
New York, NY 10108-0975

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		
Worker's Compensation.		
Qualified Military Leave		

Provide any documentation to support these breaks in service.

If you have worked for other employers in an 1199SEIU, 1115, 758 and or 144 position, or if you have worked in the healthcare or human industry, please provide the information requested below:

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

RULES AND REQUIREMENTS

- A. To assure prompt processing of your entitlement for pension benefit, this application should be completed and submitted to the Pension Fund Office before your retirement. You must complete the above information, which indicates when you want your monthly pension payments to begin. If eligible, your pension benefits will begin the month following the date that you filed the application and submitted all the required documentation.
- B. If you are married, and you and your spouse choose the Joint & 50 % Survivor Option, you must promptly submit proof of your spouse's date of birth to the Pension Fund Office.
- C. If you are married, and you and your spouse choose the Lifetime Pension with 60-month Guaranteed Option or the Joint and 75% Survivor Option, the Spousal Waiver Agreement in this application must be completed and signed by your spouse.
- D. You may change your option election and beneficiary at any time before your pension payments begin. To change the beneficiary, you must complete a new designated beneficiary form for the 60-month guaranteed pension option. If your spouse has retained the right to consent to subsequent changes in the beneficiary, you will also need to complete and sign a new spousal waiver form to make this change.
- E. If you have been awarded a Social Security Disability award and have at least 15 pension credits, you may be eligible for Disability Pension Benefits.

C. IF YOU BECOME DISABLED

You may qualify for a Disability Pension Benefit if you:

- Are approved for Social Security Disability Benefits, and
- Are both totally and permanently disabled, and
- Have a disability that has continued for a period of 6 months, and
- Have at least 15 Pension Credits, and
- Be at least age 50, but younger than age 63, and
- Have worked in Covered Employment for an employer contributing to the Pension Fund for at least 436 hours in the 24 months before you became disabled, and
- Have filed an application for a Disability Pension with the Pension Fund Office within the later of: 18 months after the date your disability commenced, or within 6 months after receiving a determination of disability from Social Security Administration.

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 Benefit Award. 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 7th month of disability, provided you have filed a completed pension application along with all the required documentation within 18 months of the date your disability commenced or within 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 equal to the (REGULAR OR DEFERRED PENSION) to which you would have been entitled 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.

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 _____
NAME OF SPOUSE, on _____, in _____

We have not been living together since _____, and I have not seen or heard from my spouse
DATE
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:

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:

both certified and regular mail. The returned unopened envelopes are attached.
Telephone: () _____
3. I have written to _____, a relative of my spouse at:

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

both certified and regular mail. The returned unopened envelopes are attached.
Telephone: () _____
5. I have written to children of the marriage at:

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____
Day Month Year

NOTARY PUBLIC

List of Enclosures: _____

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OFFICE USE ONLY

Date Received ___/___/___ Interview Date ___/___/___ 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 For the period(s)/year(s): _____
(If you check this block, tell us below why you need this information.)

Certified Total Earnings For Each Year. For the year(s): _____
(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)

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 payable to "Social Security Administration"
 - DO NOT SEND CASH.
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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: **Exception:** If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300
