

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK



## APPLICATION FOR NORMAL, EARLY OR DISABILITY PENSION

### 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 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 for you and your spouse (if married): Birth Certificate, Naturalization Papers, Passport, or other official documents. (No Driver's License accepted)
  - b. **For your spouse or beneficiary,** if you choose a Joint and Survivor Pension Option: 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. Social Security Card for you, spouse or beneficiary
3. **Remember to sign and date this application at the bottom of Section D 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 the Home Care Industry or another Union covered by the SEIU, please complete the attached Request for Social Security Earnings Information form.

PLEASE MAIL YOUR COMPLETED APPLICATION (WITH COPIES OF REQUIRED DOCUMENTS) TO:

1199SEIU Home Care Employees Pension Fund

Times Square Station

PO Box 838

New York, NY 10108-0838



# 1199SEIU Home 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 NORMAL, EARLY OR DISABILITY PENSION

*This application must be completed and submitted to the Pension Fund before your intended retirement date.*

Please complete all items on this form (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 spouse's death \_\_\_/\_\_\_/\_\_\_

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

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

## B. EMPLOYMENT HISTORY

### Current Employment Information

Where employed (or last employed) in the Home Care Industry:

Agency \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Job Title \_\_\_\_\_

Date Started \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

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

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		

**Provide any documentation to support these breaks in service.**

Reason for Retirement: \_\_\_\_\_

### Prior Employment Information

If you have worked for other employers in the Home Care Industry or another Union covered by the SEIU, please provide this information:

Name of Agency	City, State	Hours Worked Per Week	Mo. Yr. Started/ Mo. Yr. Left
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### C. IF YOU BECOME DISABLED

You may qualify for a Disability Pension Benefit if you:

- You have received a Social Security Disability award, and
- Are both totally and permanently disabled, and
- You have at least 10 Pension Credits (at least ¼ credit must be earned during the Contribution Period), and
- You worked in Covered Employment for at least 1,000 hours in the period consisting of the calendar year in which you became disabled and the previous calendar year, and
- The condition or event which led to your disability occurred on or before your last day working in Covered Employment.

**A Disability Pension is not automatic. You must apply for this benefit with the Pension Fund.**

Your Disability Pension will be paid in an amount calculated the same way as the Early Retirement Pension. If you are younger than age 55, your benefit will be calculated based on the assumption that you are age 55.

No pension benefits shall be payable for any month for which you receive wage indemnification for disability under the State of New York Disability Benefits Law.

### D. EMPLOYMENT AFTER RETIREMENT

I understand that if I return to any type of employment specified below, my pension benefits will be suspended for the duration of such Totally Disqualifying Employment. Totally Disqualifying Employment means employment for which contributions are payable to the 1199SEIU National Benefit Fund for Home Care Employees, 1199SEIU Home Care Employee Pension Fund, or any place within the jurisdiction of the Union.

If you retire before you reach Normal Retirement Age, your benefits will be suspended for any month or months in which you undertake any Totally Disqualifying Employment as described above. If you retire after reaching Normal Retirement Age, your benefits will be suspended for any months in which you work over forty (40) hours, subject to the rules governing payments for working members after attaining age 70 ½.

**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.**

### E. SOCIAL SECURITY AUTHORIZATION

I understand that in order to process my 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 Pension 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.

### PENSIONER MUST SIGN HERE AFTER COMPLETING THIS APPLICATION

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

## Disability/Workman's Compensation Questionnaire

Please inform the Fund of any disability you had during your time of employment. Additional pension credits may be earned for disability.

If you have received payment from New York State Disability or your Workman's Compensation carrier, you must forward to the Fund the last check stub or a statement of disability, or compensation payments for consideration, which must state your date of injury or illness.

**Please check the appropriate space below:**

.....  
Did you receive payments for disability during or shortly after you left employment?

- Yes, I did receive disability payments during or shortly after leaving employment (Please find the enclosed proof requested as stated above).
- No, I did not receive any type of disability payments.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_



# 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 Home 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  
DATE  
spouse 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

.....  
**OFFICE USE ONLY**

Date Received \_\_\_/\_\_\_/\_\_\_ Interview Date \_\_\_/\_\_\_/\_\_\_ Interviewed by \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

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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) _____

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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.

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