This document is FOR REVIEW ONLY. You must fill out and submit the packet on the Local 246 website via DocuSign: **New Member Welcome Packet**

NYC SEIU LOCAL 246
217 Broadway, Suite 501, New York, NY 10007
212.233.0616

MEMBERSHIP APPLICATION FORM

I hereby request and accept membership in the New York City S.E.I.U. Local 246, AFL-CIO ("Local 246") and agree to be bound by the Local 246's Constitution and By-Laws and amendments thereto, now in effect or hereinafter enacted by Local 246. Subject to Mayor's Executive Order No. 98, dated May 15, 1969 and Mayor's Executive Order No. 107, dated December 29, 1986 and relevant State and City laws, rules, regulations, orders and the amendments thereto now in effect, I authorize my Employer to deduct in each regular payroll from my salary/wages Local 246's amount and any duly authorized dues increase. I understand that the New York City S.E.I.U. Local 246, AFL-CIO Constitution and By-Laws require me to pay dues to maintain continuity of membership. My membership in the New York City S.E.I.U. Local 246, AFL-CIO shall be continuous unless I notify the Treasurer in writing that I intend to resign.

Member First Name MI Last Name

Social Security Number

Employer - NYC Agency/Department Unit

Unit/Work Address

City State Zip Code

Work Phone Work Email Address

Title

Home Address

City State Zip Code

Mobile Phone Home Phone

Personal Email

Signature of Member Date

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WE KEEP NEW YORK CITY ROLLING

DUES ASSIGNMENT AND DEDUCTION AUTHORIZATION

I hereby assign to the New York City S.E.I.U. Local 246, AFL-CIO ("Local 246"), from my compensation as an employee of the Agency/Department of the City of New York ("employer"), the Union's current dues amount and any duly authorized dues increase, to be deducted in each regular payroll from my salary/wages all Union dues and other fees or assessments as shall be certified by the New York City S.E.I.U. Local 246, AFL-CIO, under its Constitution and By-Laws and to remit those amounts to the New York City S.E.I.U. Local 246, AFL-CIO.

This assignment and authorization shall remain in effect and be irrevocable, regardless of whether I am or remain a member of the New York City S.E.I.U. Local 246, AFL-CIO until December 31 following the date of authorization and shall renew from year to year on January 1 unless I revoke it by sending written notice notarized to the New York City S.E.I.U. Local 246, AFL-CIO, and the employer, the Agency/Department of the City of New York, postmarked and received by registered mail with my valid signature to both the employer and S.E.I.U. Local 246 during the period not less than 30 days and not more than 45 days before the annual anniversary date of this agreement or the date of termination of the applicable contract between the Employer and S.E.I.U. Local 246, whichever occurs sooner. The New York City S.E.I.U. Local 246, AFL-CIO is authorized to use this assignment and authorization with my current employer and with any other employer in the event I change employers or obtain additional employment, but remain within a bargaining unit represented by the New York City S.E.I.U. Local 246, AFL-CIO.

Should any provision of this assignment and authorization be adjudged unenforceable by a final decision of a Court of Administrative Agency, the invalidated provision shall be enforced to the full extent of the law and shall not affect the validity of the remainder of this agreement.

Member First Name | MI | Last Name | Employee ID #

Street Address

City | State | Zip Code

Home Phone | Mobile Phone

Personal Email Address | Work Email Address

Job Title | Social Security Number | NYC ID Number

Agency | Agency/Work Phone

Agency/Work Street Address

City | State | Zip Code

Signature of Member | Date

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INFORMATION FOR WELFARE BENEFITS

Please complete this **entire form** and attach necessary documents before clicking finish.

SECTION A: MEMBER INFORMATION

First Name	MI	Last Name	Social Security Number

Date of Birth	Date of Hire	Dept/Agency

Home Address: House #	Street	Apt. #	City	State	Zip Code

Cell Phone with Area Code	Home Phone with Area Code	Work Phone with Area Code

Personal Email Address	Work Email Address

SECTION B: SPOUSE/DOMESTIC PARTNER INFORMATION

(If you enroll a spouse or domestic partner, you must attach a marriage certificate or registration of domestic partnership before any benefits will be provided.)

Are You Enrolling a Spouse or Domestic Partner? YES NO

First Name	MI	Last Name	Social Security Number of Spouse/Domestic Partner

Date of Birth	Name of Employer	Date of Hire

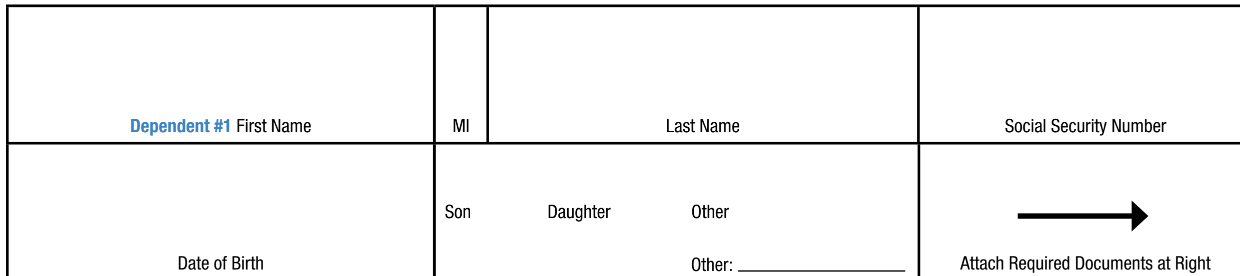
Work Address: Street	City	State	Zip Code	Work Phone with Area Code

Benefit	Name of Insurer	Address/Zip Code of Insurer	Phone # of Insurer	Policy #	Coverage: Ind/Family
Dental					
Health Ins					
Prescription					
Optical					

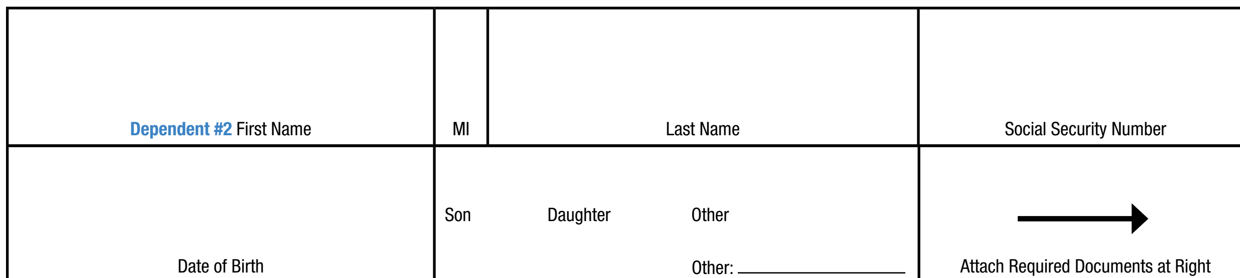
SECTION C: DEPENDENT INFORMATION

(If you enroll dependents, you must submit a birth certificate or adoption documents for each dependent before any benefits will be provided. If you have additional dependents, please contact Local 246 for an additional sheet.)

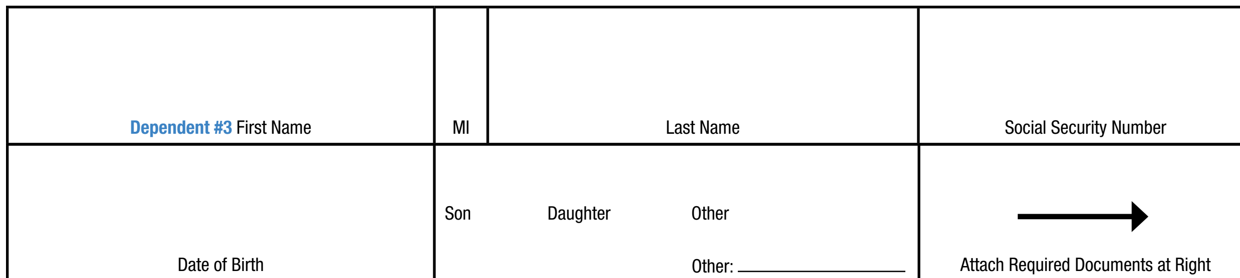
ARE YOU ENROLLING ANY DEPENDENTS? **YES** **NO**



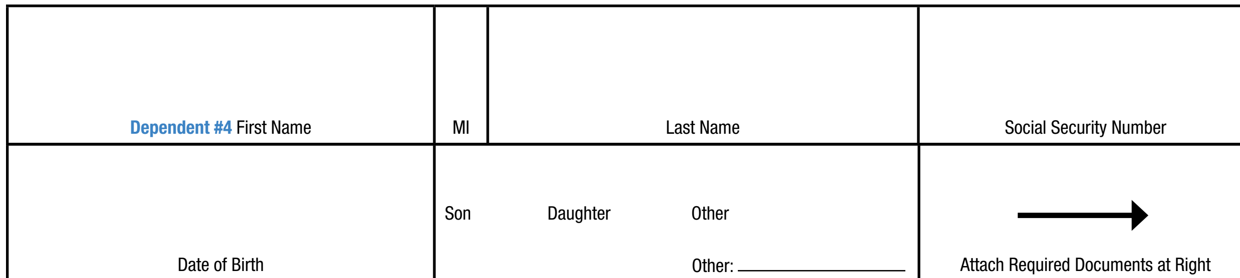
Dependent #1 First Name	MI	Last Name	Social Security Number
Date of Birth	Son Daughter Other Other: ____________		→ Attach Required Documents at Right



Dependent #2 First Name	MI	Last Name	Social Security Number
Date of Birth	Son Daughter Other Other: ____________		→ Attach Required Documents at Right



Dependent #3 First Name	MI	Last Name	Social Security Number
Date of Birth	Son Daughter Other Other: ____________		→ Attach Required Documents at Right



Dependent #4 First Name	MI	Last Name	Social Security Number
Date of Birth	Son Daughter Other Other: ____________		→ Attach Required Documents at Right

SECTION D: BENEFICIARY INFORMATION

(Member death benefits will be paid to the following beneficiary (ies) and divided equally among them unless otherwise indicated. You must list at least ONE beneficiary.)

Beneficiary #1 First Name	MI	Last Name	Date of Birth

Beneficiary Street Address	Apt. #	City	State	Zip Code

Cell Phone #	Personal Email Address	Relationship	% of Benefit

Beneficiary #2 First Name	MI	Last Name	Date of Birth

Beneficiary Street Address	Apt. #	City	State	Zip Code

Cell Phone #	Personal Email Address	Relationship	% of Benefit

CONTINGENT BENEFICIARY (IES): In the event the Primary Beneficiary (ies) predeceases the Insured, I designate as Contingent Beneficiary (ies), the following:

Contingent Beneficiary #1 First Name	MI	Last Name	Date of Birth

Beneficiary Street Address	Apt. #	City	State	Zip Code

Cell Phone #	Personal Email Address	Relationship	% of Benefit

Contingent Beneficiary #2 First Name	MI	Last Name	Date of Birth

Beneficiary Street Address	Apt. #	City	State	Zip Code

Cell Phone #	Personal Email Address	Relationship	% of Benefit

I attest that the information entered on this form is true and accurate, and I understand that I and my family may lose benefit coverage if any of the information provided on this form is false.

Member Signature ______________________ Date ____________

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ANNUITY FUND BENEFICIARY DESIGNATION FORM

THIS FORM CONTROLS THE DEATH BENEFIT DISTRIBUTION OF THE ANNUITY FUND ONLY

Separate Designation Forms are required for other Benefits that may be available through the NYC SEIU Local 246 Annuity Fund

It is essential that you take the time now to designate a beneficiary for your Annuity Fund (the "Fund") benefits should you die as a participant in the Fund. If you do not do so, the benefit will be distributed in accordance with the Plan Document.

In order to designate a beneficiary to receive any Annuity Fund benefits payable in the event of your death or to update your beneficiary designation, **you must complete, sign, and date this Beneficiary Designation Form.**

These instructions will assist you in properly completing the Primary and Contingent Beneficiary sections of this Form.

1. To designate one or more beneficiaries, insert their name(s), relationship (for example, spouse, son/daughter, sister/brother, friend, etc.), social security number, address, and telephone number.
2. When multiple beneficiaries are named, benefits will be paid in equal shares to all surviving beneficiaries. (ie: if two beneficiaries are named, each beneficiary will receive 50%)
3. Contingent Beneficiaries only receive benefits if NO Primary Beneficiary is alive at the time of your death.
4. If you wish to name your estate, insert "Estate" in the blank space.
5. If you wish to designate a Trust, insert the name of the Trustee and Trust in the blank space using language substantially as follows:
   - To X Bank as Trustee, or its successor Trustee, of the John E. Jones Trust dated the _ day of ___ , 20__, including any amendments to the Trust.
6. The validity of your designation under the law is **YOUR** responsibility. Be precise and clear. You should see an attorney if you require legal advice on your beneficiary designation.
7. You may change a Beneficiary Designation **at any time**.

Primary Beneficiary(ies) receive any death benefits payable as a result of your membership in the NYC SEIU Local 246 Annuity Fund (hereinafter "Plan"). If designating more than one Primary Beneficiary, benefits will be paid in equal shares to the surviving Primary Beneficiary(ies).

Contingent Beneficiary(ies) receive any death benefits described above if they are alive at the time of your death and if NO Primary Beneficiary is alive at the time of your death. If you designate more than one Contingent Beneficiary, benefits will be paid in equal shares to the surviving Contingent Beneficiary(ies).

Changing Beneficiary(ies) You may change the designation(s) made herein at any time. Any such change shall be effective only if you you fill out and submit a new form, and it is actually received by the Trustees prior to your death. By submitting a new Beneficiary Designation Form, you revoke any Beneficiary Designations made prior to the date of the new designation. By completing the form below, you authorize payment to the beneficiary(ies) whom you have designated and agree, on behalf of yourself and your heirs, that payment made to such beneficiaries shall be a complete discharge of any claim for such benefits and shall constitute a release of the Plan from any further obligation.

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ANNUITY FUND BENEFICIARY DESIGNATION FORM

SECTION I: MEMBER INFORMATION

Member First Name | MI | Last Name

Address

City | State | Zip Code

Home Phone | Personal Email Address

If you do not have a home phone, please retype your mobile number

Mobile Phone | Work Email Address

If you do not have a work email, type N/A

Job Title | Social Security Number

Job Location | Agency

Date First Employed By Department

SECTION II: PRIMARY BENEFICIARY INFORMATION (See First Page for Definition)

Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

SECTION II: PRIMARY BENEFICIARY INFORMATION (Continued)

Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

SECTION III: CONTINGENT BENEFICIARY INFORMATION (See First Page for Definition)

Contingent Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

Contingent Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

Contingent Beneficiary Full Name | Relationship | % of Benefit

Address | City | State | Zip Code

Mobile Phone | Email | SSN | Date of Birth

SECTION IV: AUTHORIZATION (This Form Must Be Signed and Witnessed)

*****Form must be witnessed by a person *not* named as a primary beneficiary or contingent beneficiary*****

By my signature below, I revoke any Beneficiary Designations previously made, authorize payment to the beneficiary(ies) designated above, and agree, on behalf of myself and my heirs, that payment made to such beneficiaries shall be a complete discharge of any claim for such benefits and shall constitute a release of the Plan from any further obligation.

Signature of Member | Date

Member Name (Print)

Signature of Witness | Date

Witness Name (Print)

Witness' Complete Address