IMPORTANT INSTRUCTIONS TO HELP YOU ENROLL IN THE FUND

Welcome to the 1199SEIU National Benefit Fund. To help you properly enroll in the Fund, please follow these instructions while completing the attached "Enrollment Form." Be assured that any information that you provide about yourself, your spouse and/or dependent(s) will be held in strictest confidence. Where applicable, answer each question completely (including the beneficiary section). Remember to attach a clear copy of any legal document(s) that need to accompany your enrollment form ***(do not send originals).***

Please make sure that you **sign and date the form,** then mail it in the enclosed envelope along with the required documents to the:

1199SEIU National Benefit Fund for Health and Human Service Employees
Times Square Station
Member Eligibility
P.O. Box 1035, New York, New York 10108-1035

The Fund will be unable to send your Health Service Identification card or provide benefits to you or your eligible dependents if you do not complete this Enrollment Form and provide the required documents.

Call the Benefit Fund at (646) 473-9200 if you have any questions or need assistance in completing the form.

MEMBER INFORMATION — SECTION ONE

In the spaces provided, please print your last name, first name and middle initial. Include your correct social security number, date of birth, sex, home address *(including your apartment number)*, area code and home phone number.

• **Your Spouse** – If you are married, and wish to enroll your spouse, complete items 7 through 11. Be sure to fill in your **spouse's social security number and** attach a copy of **your marriage certificate** and **your social security card.** *Without both of these items, we will be unable to enroll your spouse.* If you wish to enroll your **same sex domestic partner,** please contact the Benefit Fund directly at (646) 473-9200 for information about what additional documents must accompany this form.

• **Your Child(ren)** – If you wish to enroll your dependent child(ren), print the first and last name of each child, followed by his/her date of birth, sex and social security number. If additional space is required, please attach a separate sheet. Please make sure that you include a copy of each dependent(s) birth certificate and your social security card. Include Adoption Papers or a Court Placement Letter where applicable. *Failure to provide us with these documents will prevent your child(ren) from being enrolled.*

YOUR 1199SEIU EMPLOYER AND PRIOR EMPLOYMENT HISTORY — SECTION TWO

• ***Your Current 1199SEIU Employer*** – Please tell us you are currently working: In the spaces provided, please print the name and address of the **place where you are currently working. Next to item 19 on the form, fill in the month, day and the year you started working there. Please complete items 20 through 23. If you are a Registered Nurse, please ✔ item 24.**

Multiple Employers:
• If you are currently working for another employer, please tell us this information by filling in items 25 through 30.

• **Your Prior Employment History** – Print the name and address of your last two (2) employers. Check ✔ 'Yes' or 'No' to indicate whether any of these employers were affiliated with 1199SEIU. Indicate the date you first started working there and the date your employment ended.

COORDINATION OF BENEFITS — SECTION THREE

You, Your Child, Your Spouse

☞ YOU – If you are currently being covered by any other **health insurer, other than** the Benefit Fund, please complete items 35 through 40.

☞ YOUR SPOUSE – Does your spouse work? If 'YES,' please print the name, address and phone number of his or her employer in items 32 through 34. Does that employer provide insurance coverage for your spouse? If your answer is 'YES,' then please complete items 35 through 40.

☞ YOUR CHILD – Is your child covered by any other health insurance through your spouse, Medicaid, or another parent? If your answer is 'YES,' then please complete items 35 through 40, and 41 through 47, if applicable.

If you are not sure about the health insurance status of either your spouse or children, simply indicate the name of the Employer or other insurance carrier who may be providing coverage for them and we'll try to research the information. On the other hand, if you know for sure that there is no other health insurance, please ✔ 'NO.'

BENEFICIARY INFORMATION — SECTION FOUR

☞ In the spaces provided, print the last name, first name, social security number, address, and date of birth of the person(s) to whom your Life Insurance is to be paid. State how the person(s) is related to you. *If the person is a minor (under age 18), indicate the name of the person who will act as the Guardian until the minor attains age 18 in the "Remarks" section.*

Please ✔ check the "Primary" box for the person to whom you want this benefit paid. If you want to list someone else in case your primary choice dies before you, mark this person as "Secondary."

This Beneficiary designation will not be legal unless you have signed this form.

INSTRUCCIONES IMPORTANTES PARA AYUDARLE A INSCRIBIRSE EN EL FONDO

Bienvenido al Fondo Nacional de Beneficio de la 1199SEIU. Para ayudarle a inscribirse en el Fondo, sírvase seguir estas instrucciones al llenar el "Formulario de inscripción" adjunto. Tenga la seguridad de que cualquier información suministrada por usted con respecto a usted mismo, su cónyuge y/o sus dependientes se mantendrá estrictamente confidencial. Según sea aplicable, conteste cada pregunta completamente (incluso la sección de beneficiarios). Recuerde anexar una copia claramente legible de cualquier documento legal que debe incluir con su formulario de inscripción ***(no envíe los originales).***

Por favor este seguro de firmar y indicar la fecha en el formulario, despues envielo en el sobre contenido adjunto a los documentos requeridos a la:

1199SEIU National Benefit Fund for Health and Human Service Employees
Times Square Station
Member Eligibility
P.O. Box 1035
New York, New York 10108-1035

El Fondo no podrá enviarle su carnet de Identificación de Servicios Médicos ni proporcionar beneficios a usted o a sus dependientes elegibles si no llena este Formulario de Inscripción y no incluye los documentos necesarios.

Llame al Fondo de Beneficios al (646) 473-9200 si tiene alguna pregunta o necesita ayuda para completar el formulario.

DATOS DEL MIEMBRO — SECCIÓN UNO

En los espacios provistos, sírvase escribir en letra de molde su apellido, nombre e inicial. Incluya su número de seguro social correcto, fecha de nacimiento, sexo, dirección de su domicilio *(incluso el número de su apartamento)*, código de área y número de teléfono de su domicilio.

• **Su cónyuge**—Si usted está casado y desea inscribir a su cónyuge,llene los renglones 7 al 11. Cerciórese de llenar el número de seguro social de su cónyuge y de anexar una copia de su certificado de matrimionio y su tarjeta de seguro social. *Si omite cualquiera de estos dos requisitos, no podremos inscribir a su cónyuge.* Si desea inscribir a su compañero de vida del mismo sexo, sírvase comunicarse directamente con el Fondo de Beneficios al (646) 473-9200 para información con respecto a los documentos adicionales que debe remitir con este formulario.

• **Sus hijos/as**—Si desea inscribir a sus hijos/as dependientes, escriba en letra de molde el nombre y apellido de cada hijo/a, seguido de su fecha de nacimiento, sexo y número de seguro social. Cerciórese de incluir una copia del certificado de nacimiento de cada dependiente y su tarjeta de seguro social. Incluya los Documentos de Adopción o una Carta de Tutelaje del Tribunal, cuando así sea necesario. *Si no nos proporciona estos documentos, no podremos inscribir a sus hijos/as.*

SU EMPLEADOR 1199SEIU Y SUS ANTECEDENTES DE EMPLEO ANTERIORES — SECCIÓN DOS

• ***Su Empleador 1199SEIU Actual*** — **Sírvase indicarnos dónde trabaja actualmente: En los espacios provistos, escriba en letra de molde el nombre y dirección del lugar donde trabaja actualmente. Al lado del renglón 19 en el formulario, indique el mes, día y año en que comenzó a trabajar en dicho lugar. Sírvase llenar los renglones 20 al 23. Si usted es Enfermera Registrada, sírvase marcar con un ✔ el renglón 24.**

Múltiples empleadores

• Si usted trabaja actualmente para otro empleador, sírvase indicarnos esta información, llenando los renglones 25 al 30.

• **Sus Antecedentes de Empleos Anteriores** — Escriba en letra de molde el nombre y dirección de sus últimos dos (2) empleadores. Marque ✔ bajo "si" o "no" para indicar si alguno de estos empleadores estuvo afiliado con la 1199SEIU. Indique la fecha en que comenzó a trabajar en dicho lugar y la fecha de terminación de su empleo.

COORDINACIÓN DE BENEFICIOS — SECCIÓN TRES

Usted, su hijo/a, su cónyuge

☞ USTED — Si usted está cubierto actualmente bajo cualquier otro plan de seguro que no sea el Fondo de Beneficios, sírvase completar los renglones 35 al 40.

☞ SU CÓNYUGE — ¿Trabaja su cónyuge? Si la respuesta es "SÍ", sírvase escribir en letra de molde el nombre, dirección y número de teléfono del empleador de su cónyuge en los renglones 32 al 34. ¿Proporciona dicho empleador cobertura de seguro para su cónyuge? Si la respuesta es "SÍ", sírvase llenar los renglones 35 al 40.

☞ SU HIJO/A — ¿Está su hijo/a cubierto bajo cualquier otro seguro médico de su cónyuge, Medicaid o su otro padre/madre? Si la respuesta es "SÍ", sírvase llenar los renglones 35 al 40 y 41 al 47, en su caso.

Si no está seguro con respecto a la cobertura médica de su cónyuge o sus hijos/as, indique simplemente el nombre del empleador u otro asegurador que podría proporcionarles cobertura, y procuraremos obtener la información. Por otra parte, si sabe que sin duda no hay otro seguro médico, sírvase marcar ✔ NO.

DATOS DE LOS BENEFICIOS — SECCIÓN CUATRO

☞ En los espacios provistos, escriba en letra de molde el apellido, nombre, número de seguro social, dirección y fecha de nacimiento de la persona o personas a las cuales debe pagarse su seguro de vida. Indique el parentesco que dicha persona tiene con usted. *Si el beneficiario es un menor de edad (menor de 18 años), indique en la sección titulada "Comentarios" el nombre de la persona que actuará de tutor hasta que el menor cumpla los 18 años de edad.*

Sírvase marcar ✔ en la casilla "Primario" para indicar la persona a la cual desea que se pague este beneficio. Si desea incluir a otro beneficiario, en caso de que su beneficiario primario muriera antes de usted, marque esta persona como beneficiario "Secundario".

Esta designación de beneficiario carecerá de validez legal salvo que usted haya firmado esta formulario.

1199SEIU National Benefit Fund

Times Square Station, Member Eligibility, P.O. Box 1035, New York, N.Y. 10108-1035

ENROLLMENT FORM
Formulario de Inscripción

THIS FORM IS STRICTLY CONFIDENTIAL. YOU MUST ANSWER ALL THE QUESTIONS. PRINT CLEARLY IN INK AND SIGN THE BACK.

ESTE FORMULARIO ES ESTRICTAMENTE CONFIDENCIAL. USTED DEBE CONTESTAR TODAS LAS PREGUNTAS. ESCRIBA CON TINTA EN LETRA DE MOLDE Y FIRME EL FORMULARIO AL DORSO.

MEMBER INFORMATION / *DATOS DEL MIEMBRO* — SECTION ONE / *SECCIÓN UNO*

1. MEMBER NAME *Nombre del Miembro* (Last) *(Apellido)* | (First) *(Nombre)* | (M.I.) *(Inicial)*

2. SOCIAL SECURITY NUMBER *Número de Seguro Social*

3. DATE OF BIRTH *Fecha de Nacimiento* Mo *Mes* / Day *Día* / Year *Año*

4. SEX *Sexo* M ☐ F ☐

5. ADDRESS *Dirección* APT. # *Apartamento #*

CITY *Ciudad* STATE *Estado* ZIP CODE *Zona Postal*

6. AREA CODE & HOME PHONE NUMBER *Código de área y número de teléfono residencial*

7. MARITAL STATUS *Estado Civil*

8. MARRIAGE DATE *Fecha de Matrimonio* Mo *Mes* / Day *Día* / Year *Año*

8A. For purposes of statistical/demographic information, we ask you to provide the following information.
PLEASE CHECK ONE: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other
Para propositos de información estadística/demografica, solicitamos nos puedan proveer la siguiente información.
Por favor marque una: ☐ *Blanco* ☐ *Negro* ☐ *Latino* ☐ *Asiatico* ☐ *Otro*

6A. E-MAIL *Correo Electrónico*

9. SPOUSE'S FULL NAME (Last, First, Middle Initial) Attach copy of Marriage Certificate and social security card.
Nombre completo del cónyuge (Apellido, Nombre, Inicial) Anexe una Copia del Certificado de Matrimonio y la tarjeta de seguro social

10. SPOUSE'S BIRTH DATE *Fecha de nacimiento del cónyuge* Mo *Mes* / Day *Día* / Year *Año*

11. SPOUSE'S SOCIAL SECURITY NUMBER *Número de Seguro Social del cónyuge*

12. YOUR CHILD(REN)'S NAME(S) Attach copy of Birth Certificate and social security card for each dependent. *Los nombres de sus hijos(as) Anexe una copia del certificado de nacimiento y la tarjeta de seguro social de cada dependiente*	13. SEX *Sexo*	14. DATE OF BIRTH *Fecha de Nacimiento* Mo *Mes* / Day *Día* / Year *Año*	15. RELATIONSHIP *Parentesco*	16. SOCIAL SECURITY NUMBER *Número de Seguro Social*
1	☐F ☐M			
2	☐F ☐M			
3	☐F ☐M			
4	☐F ☐M			
5	☐F ☐M			

1199SEIU EMPLOYER & EMPLOYMENT HISTORY / *EMPLEADOR 1199 Y SUS ANTECEDENTES DE EMPLEO ANTERIORES* — SECTION TWO / *SECCIÓN DOS*

YOUR 1199SEIU EMPLOYER
17. *Su empleador 1199SEIU* _____ WORK PHONE *Número del teléphono del empleador* _____

18. ADDRESS *Dirección* _____

CITY *Ciudad* _____ STATE *Estado* _____ ZIP *Zona Postal* _____

19. STARTING DATE *Fecha de Comienzo* _____ 20. ☐ FULL-TIME ☐ PART-TIME ☐ PER DIEM ☐ TEMP. *Tiempo Completo Tiempo Parcial Jornalero Temp.* 21. HOURS PER WEEK *Horas por semana* _____ PAY PER WEEK $ *Pago por semana $* _____

22. JOB TITLE *Título del Cargo* _____ 23. DEPT. *Departamento* _____ 24. CHECK BOX IF REGISTERED NURSE *Marque esta casilla si es enfermera registrada* ☐

25. IF YOU WORK FOR ANOTHER 1199SEIU EMPLOYER, NAME OF OTHER EMPLOYER _____
Si trabaja para otro empleador 1199SEIU, nombre del otro empleador

26. ADDRESS *Dirección* _____

CITY *Ciudad* _____ STATE *Estado* _____ ZIP *Zona Postal* _____

27. STARTING DATE *Fecha de Comienzo* _____ 28. ☐ FULL-TIME ☐ PART-TIME ☐ PER DIEM ☐ TEMP. *Tiempo Completo Tiempo Parcial Jornalero Temp.* 29. HOURS PER WEEK *Horas por semana* _____ 30. PAY PER WEEK $ *Pago por semana $* _____

31. PLEASE INDICATE PREVIOUS EMPLOYMENT *Por favor indique el empleo anterior*

	EMPLOYER *Empleador*	1199SEIU JOB *Empleo 1199SEIU* YES *Sí*	NO *No*	CITY *Ciudad*	STATE *Estado*	DATE STARTED *Fecha de Comienzo* MONTH *Mes*	DAY *Día*	YEAR *Año*	DATE ENDED *Fecha de Terminación* MONTH *Mes*	DAY *Día*	YEAR *Año*
1											
2											

PLEASE CONTINUE COMPLETION OF THIS FORM ON REVERSE SIDE *Sírvase continuar llenando el formulario al dorso*

COORDINATION OF BENEFITS – OTHER HEALTH INSURANCE / *COORDINACIÓN DE BENEFICIOS — OTRO SEGURO MÉDICO* — SECTION THREE / *SECCIÓN TRES*

32. NAME OF SPOUSE'S EMPLOYER _____
Nombre del empleador del cónyuge

33. EMPLOYER'S ADDRESS _____
Dirección del empleador

CITY _____ STATE _____ ZIP _____
Ciudad *Estado* *Zona Postal*

34. DOES YOUR SPOUSE HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO
¿Tiene su cónyuge otra cobertura de seguro médico *Sí* *No*

35. IF YES, NAME OF INSURANCE PLAN _____
Si la respuesta es sí, nombre del plan de seguro

36. POLICY/GROUP NUMBER _____
Número de póliza/grupo

37. Please indicate the type of coverage: Hospital ☐ Surgical ☐ Major Medical ☐
Por favor indique el tipo de cobertura: Hospital Quirúrgico Médico mayor
Medical (Office Visits, Lab) ☐ Vision ☐ Dental ☐
Médico (Visitas al consultorio, análisis de laboratorio) Visión Dental

38. DOES THIS PLAN ALSO INCLUDE PRESCRIPTION COVERAGE? ☐ YES ☐ NO
¿Incluye este plan también la cobertura de receta medica? Sí No

39. EFFECTIVE DATE OF COVERAGE _____
Fecha efectiva de la cobertura

40. IS THIS COVERAGE INDIVIDUAL OR FAMILY? ☐ IND. ☐ FAMILY
¿Es esta cobertura individual o familiar? Ind. Familiar

41. DOES YOUR DEPENDENT CHILD(REN) HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO
¿Tienen sus hijos/as dependientes otro seguro médico? Sí No

42. IS THIS INSURANCE THE SAME AS ABOVE? ☐ YES ☐ NO
¿Es este seguro el mismo que el indicado arriba? Sí No

43. NAME OF OTHER PARENT _____
Nombre del otro padre/madre

44. NAME OF OTHER PARENT'S EMPLOYER _____
Nombre del empleador del otro padre/madre

45. ADDRESS OF OTHER PARENT'S EMPLOYER _____
Dirección del empleador del otro padre/madre

CITY _____ STATE _____ ZIP _____
Ciudad *Estado* *Zona Postal*

46. SOCIAL SECURITY NUMBER _____
Número de Seguro Social

47. DATE OF BIRTH _____
Fecha de nacimiento

BENEFICIARY INFORMATION / *DATOS DE BENEFICIARIOS* — SECTION FOUR / *SECCIÓN CUATRO*

BENEFICIARY INFORMATION—FOR YOUR LIFE INSURANCE. **Insert name and address of person(s) to whom your Life Insurance is to be paid. State how the person(s) are related to you. If a minor (under age 18), state age, and indicate the name of the person who will act as the Guardian in the Remarks Section below until the minor attains age 18.** Please check the **PRIMARY** box for the person to whom you want this benefit paid. If you want to list someone else in case your **PRIMARY** choice dies before you, mark this person or person(s) as **SECONDARY.** If you want more than one person to share equally in this benefit, those individuals must be marked as **PRIMARY.** If additional space is needed, please use the "Remarks" section below or attach a separate sheet. If you authorize the Fund to assign up to 1/3 of your insurance benefit directly to the Funeral Home or cemetery, in the event that the Fund is notified that your funeral expenses have not been otherwise paid or guaranteed to be paid, check the following box. ☐

DATOS DE BENEFICIARIOS — DE SU SEGURO DE VIDA. Indique el nombre y dirección de la persona o personas a las cuales deberá pagarse su seguro de vida. Indique el parentesco que tiene dicha persona o personas con usted. En caso de un menor de edad (menor de 18 años de edad), indique en la sección titulada "Comentarios" más abajo la edad y el nombre de la persona que actuará como tutor hasta que el menor cumpla los 18 años de edad. *Sírvase marcar la casilla* ***PRIMARIO*** *para indicar la persona a la cual desea que se pague este beneficio. Si desea designar a otra persona en caso de que su beneficiario* ***PRIMARIO*** *muriera antes que usted, marque la casilla* ***SECUNDARIO*** *al lado de esta persona. Si desea que este beneficio sea compartido a partes iguales entre más de una persona, dichas personas deberán indicarse como beneficiarios* ***PRIMARIOS.*** *Si necesita más espacio, sírvase usar la sección titulada "Comentarios" más abajo o anexar una hoja adicional. Si usted desea autorizar al Fondo que asigne hasta 1/3 de su beneficio de seguro de vida directamente a la Funeraria o cementerio en caso de que el Fondo sea notificado de que no han sido pagados o no se ha garantizado el pago de sus gastos de entierro, sírvase marcar esta casilla.* ☐

48. NAME OF BENEFICIARY(Last, First, Middle Initial) *Nombre del beneficiario (Apellido, nombre, inicial)*	SOCIAL SECURITY NUMBER *Número de Seguro Social*	☐ Primary *Primario* ☐ Secondary *Secundario*	RELATIONSHIP TO MEMBER *Parentesco con el Miembro*	BIRTH DATE (if under 18) *Fecha de Nacimiento (menores de 18 años de edad)* Mo *Mes* Day *Día* Year *Año*
STREET ADDRESS OF BENEFICIARY *Dirección Postal del Beneficiario*	CITY *Ciudad*		STATE *Estado*	ZIP CODE *Zona Postal*
49. NAME OF BENEFICIARY(Last, First, Middle Initial) *Nombre del Beneficiario (Apellido, nombre, inicial)*	SOCIAL SECURITY NUMBER *Número de Seguro Social*	☐ Primary *Primario* ☐ Secondary *Secundario*	RELATIONSHIP TO MEMBER *Parentesco con el Miembro*	BIRTH DATE (if under 18) *Fecha de Nacimiento (menores de 18 años de edad)* Mo *Mes* Day *Día* Year *Año*
STREET ADDRESS OF BENEFICIARY *Dirección Postal del Beneficiario*	CITY *Ciudad*		STATE *Estado*	ZIP CODE *Zona Postal*
50. NAME OF BENEFICIARY(Last, First, Middle Initial) *Nombre del Beneficiario (Apellido, nombre, inicial)*	SOCIAL SECURITY NUMBER *Número de Seguro Social*	☐ Primary *Primario* ☐ Secondary *Secundario*	RELATIONSHIP TO MEMBER *Parentesco con el Miembro*	BIRTH DATE (if under 18) *Fecha de Nacimiento (menores de 18 años de edad)* Mo *Mes* Day *Día* Year *Año*
STREET ADDRESS OF BENEFICIARY *Dirección Postal del Beneficiario*	CITY *Ciudad*		STATE *Estado*	ZIP CODE *Zona Postal*

REMARKS *Comentarios:*

This Enrollment Form is for Fund use only and will not be released to any third party except where necessary for the administration and operation of the Fund, or where otherwise required by law. THE FOREGOING STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE. I AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER HEALTH CARE PROVIDER TO RELEASE TO NBF AND ITS AGENTS ANY RECORDS OR INFORMATION, WITHOUT RESTRICTION, CONCERNING ME OR ANY MEMBER OF MY FAMILY RECEIVING BENEFITS FROM NBF. UNLESS I REVOKE IT IN WRITING, THIS AUTHORIZATION WILL BE EFFECTIVE AS LONG AS I AM A PARTICIPANT IN NBF. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I understand that under the terms of the Plan (SPD p.31), the National Benefit Fund has a right to be reimbursed for any money it pays on my behalf for expenses caused by a third party. If the Fund pays any such claims, it will have a lien on payments I receive from, or on behalf of, the third party and I agree to pay back the Fund for any payments it has made. This agreement will be effective for all benefits incurred while I am a participant in the Fund, even if I receive payments from or on behalf of a third party when I am no longer a participant. *Este formulario de inscripción es para uso por el Fondo solamente y no será divulgado a ningún tercero excepto cuando sea necesario para la administración y operación del Fondo o cuando de otra manera sea obligatorio por ley. A MI MEJOR SABER Y ENTENDER, LAS DECLARACIONES QUE ANTECEDEN SON VERDADERAS Y COMPLETAS. POR ESTE MEDIO AUTORIZO A CUALQUIER HOSPITAL, MÉDICO U OTRO PROVEEDOR DE ATENCIÓN MÉDICA PARA QUE DIVULGUE A NBF Y SUS AGENTES, CUALESQUIER EXPEDIENTES O INFORMACIÓN ALGUNA, CON RESPECTO A MÍ O A CUALQUIER MIEMBRO DE MI FAMILIA QUE RECIBIERA BENEFICIOS DE NBF. SALVO QUE REVOQUE ESTA AUTORIZACIÓN POR ESCRITO, PERMANECERÁ EN VIGOR MIENTRAS YO SEA PARTICIPANTE DE NBF. UNA FOTOCOPIA DE ESTA AUTORIZACIÓN SERÁ IGUALMENTE VÁLIDA COMO EL ORIGINAL DE LA MISMA. Entiendo que bajo los términos del Plan (SPD p. 31), National Benefit Fund tiene el derecho de ser reembolsado por cualquier dinero que pagara en mi nombre por concepto de gastos ocasionados por un tercero. Si el Fondo pagara cualquier tal reclamación, tendrá un gravamen sobre los pagos que yo recibiera de, o en nombre del tercero y acuerdo reintegrar al Fondo cualesquier pagos hechos por dicho Fondo. El presente acuerdo será válido con respecto a todos los beneficios incurridos mientras yo sea participante del Fondo, incluso si yo recibiera pagos de, o en nombre de un tercero cuando ya haya dejado de ser participante.*

MEMBER'S SIGNATURE *Firma del Miembro* _____ **DATE** *Fecha* _____

IF YOU DO NOT SIGN AND DATE THIS FORM IT WILL BE RETURNED TO YOU AND YOU WILL NOT BE ENROLLED.
SI NO FIRMA Y FECHA ESTA FORMULARIO, LE SERÁ DEVUELTO Y NO SE LE INSCRIBIRÁ.

9NBF4 • 20M • 3/09 • 47015

PROUD OF OUR UNION

1199SEIU

United Healthcare Workers East

PROUD OF OUR FUTURE

APPLICATION FOR MEMBERSHIP

Membership in 1199 is without regard to race, color, sex, sexual orientation, age, disability, religion, national origin, political belief or affiliation.

Please Print All Information Clearly

PERSONAL INFORMATION

Social Security Number | **Birth Date:**

Last Name | **First Name** | **Middle**

Street Address

City | **State** | **Zip**

Home Telephone Number (__ __ __) __ __ __ - __ __ __ __

E-Mail _____@_____

ANSWERING THE FOLLOWING QUESTIONS IS VOLUNTARY AND DOES NOT AFFECT YOUR APPLICATION FOR MEMBERSHIP

Ethnic Origin:
- ☐ White (Caucasian)
- ☐ Black
- ☐ Latino/Hispanic
- ☐ Asian/Asian American / Pacific Islander
- ☐ Native American / Alaskan Native

Sex:
- ☐ Male
- ☐ Female

Are you handicapped or disabled?
- ☐ Yes
- ☐ No

Are you a citizen of the U.S.? ☐ Yes ☐ No

If NO, which country are you a citizen of ? _____

If NO, are you interested in attending U.S. citizenship classes? ☐ Yes ☐ No

If YES, are you registered to vote? ☐ Yes ☐ No

Have you joined the 1199 Political Action Fund ☐ Yes ☐ No *(see application attached)*

Were you ever a member of 1199 before? ☐ Yes ☐ No

If YES, where? _____ From ____ (Month) / ____ (Year) To ____ (Month) / ____ (Year)

EMPLOYER INFO

Name of Institution | **Hire Date**

Address of Institution

Department | **Job Title**

Salary $ Per | **Job Telephone No.** ( ) **Extension**

Shift ☐ Day ☐ Night ☐ Evening ☐ Swing | **Hours Per Week**

SIGNATURE

I hereby accept membership in 1199SEIU United Healthcare Workers East, and designate 1199 to act for me as collective bargaining agent in all matters pertaining to conditions of employment. I hereby pledge to abide by the Constitution of 1199SEIU United Healthcare Workers East.

_____ Date

_____ Signature

PLEASE DO NOT WRITE IN SPACE BELOW
FOR MEMBERSHIP DEPARTMENT ONLY

Entered by: _____ **Date:** _____

Mailed by: _____ **Date:** _____

- ☐ New Employee
- ☐ New Organizing
- ☐ Residual Unit

Please mail to the dues department for processing ➔

UNION DUES CHECK OFF AUTHORIZATION

You are hereby authorized and directed to deduct an initiation fee from my wages or salary as required by 1199 SEIU United Healthcare Workers East as a condition of my membership; and in addition thereto, to deduct my membership dues from my wages or salary; and in addition thereto, to deduct each month an amount equal to monthly membership dues to be applied to past unpaid dues until the entire amount of unpaid past dues has been deducted and paid; and to remit all such deductions to 1199SEIU United Healthcare Workers East, 310 West 43rd Street, New York, NY 10036, no later than the tenth day of each month immediately following the date of deduction, or pursuant to the date provided in the Collective Bargaining Agreement.

This deduction is a voluntary act on my part and shall be irrevocable for a period of one (1) year or until the termination date of the Collective Bargaining Agreement, whichever is sooner, and shall, however, renew itself from year to year unless I give written notice of the revocation of this authorization addressed to the 1199SEIU Dues and Membership Department at 310 West 43rd Street, New York, NY 10036.

Signature:_____ Date:_____

Print Name:_____

Social Security No.:_____ / _____ / _____ Email:_____

Address:_____

City/State/Zip Code:_____

POLITICAL ACTION FUND CHECK OFF AUTHORIZATION

I hereby authorize 1199SEIU United Healthcare Workers East, to file this payroll deduction form on my behalf with my employer to withhold ☐ $10.00 per month or ☐ $_____ per month or ☐ $2.00 per week or ☐ $_____ per week and forward that amount to the 1199SEIU Political Action Fund, 310 West 43rd Street, New York, NY 10036. This authorization is made voluntarily based on my specific understanding that:

1. The signing of this authorization form and the making of these voluntary contributions are not conditions of my employment by my Employer or membership in any Union;
2. I may refuse to contribute without any reprisal;
3. The $10.00 monthly contribution is only a suggestion, and I may contribute more or less without fear of favor or disadvantage from 1199SEIU or my Employer; and
4. The 1199SEIU Political Action Fund uses the money it receives for political purposes, including but not limited to, making contributions to and expenditures on behalf of candidates for federal, state, local offices and addressing political issues of public importance.
5. Contributions to the 1199SEIU Political Action Fund are not deductible as charitable contributions for federal income tax purposes. Federal law requires us to use our best efforts to collect and report the name, mailing address, occupation and name of employer of individuals whose contributions exceed $200 in a calendar year.
6. This authorization shall remain in full force and effect until revoked by me in writing to the 1199SEIU Political Action Department at 330 West 42nd Street - 7th Floor, New York, NY 10036.

Signature: _____ Date: _____

Print Name: _____

Social Security No.: (Last four digits only) Email: _____

Address: _____

City/State/Zip Code: _____

Collected by _____ Membership ID # _____
(Please Print)

Please return the completed application to the Dues Department for processing:

1199SEIU United Healthcare Workers East
Dues Department
310 West 43rd Street 2nd Floor
New York, NY 10036

See Reverse for Information on Membership Rights →

MEMBERSHIP RIGHTS

Congratulations on your new job and welcome to 1199SEIU United Healthcare Workers East.

You have the opportunity to join the largest health care union, with the highest standards (wages and benefits) in the United States. 1199 is a proud union, which has been in the forefront of the struggles for workers' rights and human rights. We hope you will join with us and become an active member of 1199.

Your new job is part of the 1199 bargaining unit. Years ago employees in this job, as well as in other similar jobs, voted to be represented by 1199. Since then, the terms and conditions of employment for your new job are negotiated by the membership of 1199.

Membership in 1199 is very special. Not only are there material benefits which flow from membership, but as a member of 1199 you can participate with your co-workers in making vital decisions that affect you and your families' lives: what wage increases, health insurance and pension benefits will be in your collective bargaining agreement, whether or not you will strike, whom you entrust with the leadership of your Union. These are decisions that only Union Members can make. Union Membership also carries with it the responsibility to help finance the Union's programs through monthly dues, to ensure the strength and vitality of the Union which translates into your wage and benefit levels.

Federal law requires 1199 to notify new hires that an individual covered by a collective bargaining agreement can choose not to be a member of 1199, and still receive the terms of the collective bargaining agreement (but not the benefits of Union Membership). If you choose not to be a member, and thus to forgo the benefits of Union Membership, under the collective bargaining agreement your obligation is limited to the payment of fees equal to the initiation fee and monthly dues. In addition, under federal law you have the right to object to providing financial support to union activities not germane to collective bargaining, in which case you will be required to pay a representation fee equal to initiation fees and dues reduced proportional to the percentage of the union's total expenditures that are not germane to collective bargaining. Based upon the most recent accounting, the representation fee is just about 64% of Union dues (which will equal 1.3% of your gross pay exclusive of overtime), meaning that for the average worker the difference between monthly Union dues and the monthly representation fee is currently only about $4.00 a week. However, by choosing this option you forgo the benefits of Union Membership.

If you submit an objection, you will be provided with information reflecting the bases on which the representation fee was calculated and the procedure for challenging these calculations before a neutral arbitrator. If you choose not to be a member of 1199, and thus to limit your obligation to the payment of fees equal to the initiation fee and monthly dues, or if you wish to object to providing financial support to union activities not germane to collective bargaining, and thus to limit your obligation to the payment of a representation fee as described above, you must inform the Union in writing by sending notice of your decision to the Secretary-Treasurer, 1199SEIU United Healthcare Workers East, 310 West 43rd Street, New York, New York 10036. Please include your name, address, social security number, name of employer and work location. If you object to providing financial support to union activities not germane to collective bargaining, make sure that the notice you send to the Secretary-Treasurer includes the word "object," and that you mail your notice no later than 30 days from the date you received this Notice.

Building our political power is impossible without your contributions to our Political Action Fund.

Five dollars a month seems very small when you compare it to thousands of dollars in higher wages and first class benefits that we are able to win in our contract with the help of our Political Action Fund. That's why it's important to sign up today— so our Union has the resources necessary to make our voice heard at the bargaining table, at City Hall, the State Capitol and in Washington.