

New York State Nurses Association



PO Box 12430
Albany, NY 12212-2430
PHONE (877) RN BENEFITS
FAX (518) 456-3954
www.rnbenefits.org

Pension Plan Enrollment Card

Social Security Number _____

First Name _____ Middle Initial _____ Last Name _____
(Please use legal name only)

Street Address _____ City _____ State _____ Zip + 4 _____ - _____

Home Telephone (____) _____ Sex Male Female Date of Birth ____/____/____

E-mail address _____

Employment Date ____/____/____ RN Date ____/____/____ Employer _____

Position Title _____ Work Status Full-time Part-time _____ Hours

Signature _____ Date _____

Please fill out the back of this form

Marital Status: Single Married Divorced Legally Separated Widowed/Widower

If Married: Spouse's Full Name _____ Date of Marriage ___/___/___

Spouse's Date of Birth ___/___/___ Spouse's Social Security Number _____

If Divorced: Former Spouse's Full Name _____

Date of Marriage ___/___/___ Date of Divorce ___/___/___ Date of Birth ___/___/___

If Legally Separated: Spouse's Full Name _____

Date of Marriage ___/___/___ Date of Legal Separation ___/___/___ Date of Birth ___/___/___

If Widowed/Widower: Spouse's Full Name _____

Date of Marriage ___/___/___ Spouse's Date of Death ___/___/___ Date of Birth ___/___/___

Prior employment with employers covered by the NYSNA Pension Plan

Name of Institution _____ Date from _____ Date to _____

Name of Institution _____ Date from _____ Date to _____