New York State Nurses Association

NYSNA Pension Plan

PO Box 12430
Albany, NY 12212-2430
Phone (877) RN BENEFITS
Fax (518) 456-3954
E-mail pensions@rnbenefits.org
Internet www.rnbenefits.org

Pension Application I

The information on this form will be used to prepare your pension calculation or evaluation. It must be accurate and complete in every detail. Please date and sign the form, and promptly return it to the Plan office at the address listed above.

If you are applying for a Pension Plan death benefit, please complete only Part G on the back of this form.

Part A – Census Data

Name _____ Social Security number _____

Address _____ Date of birth _____

_____ Today's date _____

E-mail address _____ Telephone number _____

Employer _____ Date employed as an RN _____

Marital status _____ Single _____ Married _____ Widowed Date of marriage _____

_____ Divorced Date of divorce _____

Name of spouse (first, middle, last) _____

Spouse's Social Security number _____ Spouse's date of birth _____

Part B – Pension Calculation

Please calculate my pension or indicate my vesting status based on the following information (check all that apply):

❑ Normal retirement starting on _____ ❑ Disability benefit starting on _____

❑ Early retirement starting on _____ ❑ Vested status only effective _____

❑ Other (please specify) starting on _____ ❑ My last day of employment will be _____

Part C – Other Employers

Have you been employed by another employer participating in the Plan? _____ No _____ Yes (please complete below)

Employer name *Dates (M/D/Y)* *Annual base compensation* *Full or part-time* *Regular weekly hours*

_____

_____

_____

Part D – Breaks in Service

Please indicate any breaks in employment.

Date (from/to) *Reason for break* *Employer Name*

_____

_____

_____

Part E – Application Statement

I hereby apply for a pension (or vested status evaluation) as indicated in Part B and determined in accordance with the terms of the New York State Nurses Association Pension Plan. I certify that the statements I have made are true to the best of my knowledge. Further, I understand that if I return to work in covered employment at a participating employer of the New York State Nurses Association Pension Plan after my pension payments begin, such payments will be suspended during my period of re-employment.

Signature _____ **Date** _____

Please complete other side if you're applying for a disability pension or death benefit

08/17

Part F – Disability Pension

I became totally disabled on _____ I last worked on _____

The Social Security Administration found that I became disabled under their rules on _____

The first month of my entitlement to Social Security benefits is (was) _____

Please send the Plan office a copy of any notification you receive from the Social Security Administration regarding your disability.

Signature _____ **Date** _____

Part G – Death Benefit (Beneficiary's Statement)

Deceased participant's name _____ Social Security number _____

Your name _____ Your Social Security number _____

Address _____ Telephone _____

_____ Date of birth _____

Death benefit effective _____ E-mail address _____

Signature _____ **Date** _____

Please submit the following documents with this application:

- An original certified copy of the death certificate.
- Copy of your birth certificate (if you do not have a copy of your birth certificate, please submit two other forms of identification, such as your driver's license, passport, or baptismal certificate).
- Certified or notarized copies of letters testamentary (if applicable).

Emergency Contact Information

Contact name _____

Address _____ Telephone _____

_____

E-mail address _____

Relationship to Participant _____