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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, Home phone, Cell phone, Employer, Date employed as an RN, Marital status, Single, Married, Widowed, Date of marriage, Divorced, Date of divorce, Name of spouse, 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

## 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 \_\_\_\_\_ Cell phone: \_\_\_\_\_

\_\_\_\_\_ Home phone: \_\_\_\_\_

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 \_\_\_\_\_ Cell phone: \_\_\_\_\_

\_\_\_\_\_ Home phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Relationship to Participant \_\_\_\_\_