



## APPLICATION FOR DISABILITY PENSION BENEFIT

### Instructions

Follow these instructions carefully and completely to avoid delays in processing your benefit. If you wish to meet with a Retirement Counselor who can assist you with completing the application and discuss the retirement process, please contact the Fund at (646) 473-8666.

1. Read and answer each section or question that applies to you. All requested information is needed to process your application and determine the maximum amount of service and benefits for which you may qualify. If a section or question does not apply to you, please mark it "N/A" for "Not Applicable."
2. Documents Required:  
*Note:* Your pension may be **delayed** if you do not submit copies of the following documents with your application:
  - a. **Member:** Proof of Age: Birth Certificate, Naturalization Papers, Passport, or other official documents. (No Driver's License accepted)
  - b. Recent pay stub
  - c. Social Security Card
3. **Remember to sign and date this application at the bottom of Section C & Section D or it will not be valid.**
4. Keep a copy of this application for your records.
5. If you left covered employment or worked for other employers in an 1199SEIU, 1115 and/or 144 position, please complete the attached Request for Social Security Earnings Information.
6. You will not automatically get a Disability Pension. You must meet the requirements in the Plan to be entitled to Disability through SSA.

PLEASE MAIL YOUR COMPLETED APPLICATION  
(WITH COPIES OF REQUIRED DOCUMENTS) TO:

1199SEIU Health Care Employees Pension Fund  
Times Square Station  
PO Box 975  
New York, NY 10108-0975



## APPLICATION FOR DISABILITY PENSION BENEFIT

Please complete all items on this form (please print clearly in ink).

### A. PERSONAL DATA

Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
(First) (Middle) (Last)

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex  M  F

Current Marital Status:  Single  Married  Divorced  Widowed

1. If married, spouse's name \_\_\_\_\_  
(First) (Middle) (Last)

Spouse's Social Security # \_\_\_\_\_ Spouse's Date of Birth \_\_\_/\_\_\_/\_\_\_

Date of Marriage \_\_\_/\_\_\_/\_\_\_

2. If divorced, date of divorce \_\_\_/\_\_\_/\_\_\_

3. If widowed, date of death \_\_\_/\_\_\_/\_\_\_

4. If married but separated, last known address of spouse:

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone ( ) \_\_\_\_\_

I request my Disability Pension Benefit to begin on the first day of \_\_\_\_\_, 20\_\_\_\_\_  
Month Year

**B. EMPLOYMENT HISTORY**

**Current Employment Information**

Where employed (or last employed) in an 1199SEIU, 1115 or 144 position:

Institution \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Job Title \_\_\_\_\_

Date Started \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Date You Will Leave (Left) Work \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Reason for Retirement: \_\_\_\_\_

Did you work in the same position from the date you started?  Yes  No

If "No" please indicate what month, year and job title: Month/Year \_\_\_\_\_ Job Title \_\_\_\_\_

Current/Last Base Gross Salary \$ \_\_\_\_\_ or hours worked per week \_\_\_\_\_

Current Hourly Rate \$ \_\_\_\_\_

Have there ever been any breaks in service?  Yes  No

If yes, please indicate reason for Break:

	From	To
Personal Leave		
Maternity/Paternity Leave		
Disability		
FMLA Leave		
Workers' Compensation		
Qualified Military Leave		
Training & Upgrading Leave		

**Provide any documentation to support these breaks in service.**

**Prior Employment Information**

If you have worked for other employers in an 1199SEIU, 1115 and/or 144 position, or if you have worked in the healthcare or human service industry, please provide this information:

Name of Employer(s)	City, State	Job Title	Mo. Yr. Started/ Mo. Yr. Left
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Prior Pension Plan Information**

Have you ever been covered by any of the following pension plans listed?  Yes  No

- (1) Health Service Retirement Plan
- (2) Hospital League Pension Plan
- (3) Long Island Jewish Medical Center Tax Shelter Annuity
- (4) Yeshiva University Retirement Income Plan
- (5) Mt. Sinai Hospital Retirement Income Plan Employees
- (6) 1199SEIU GNY Pension Fund
- (7) SEIU Affiliates' Plan for Employees
- (8) SEIU Staff Plan for Employees
- (9) Local 721 SEIU (LPN)

a. If Yes, complete the date of enrollment in the applicable Pension Plan listed below

Pension Plan	From	To

**C. DISABLING CONDITION**

**This section must be completed before your disability application can be processed.**

Why did you terminate covered employment or Reason for Retirement? \_\_\_\_\_

What illnesses, injuries or medical conditions limits your ability to work? \_\_\_\_\_

Date of injury or illness \_\_\_\_\_, 20\_\_\_\_  
Month Year

Date you became unable to work because of your medical condition or injury \_\_\_\_\_, 20\_\_\_\_  
Month Year

Where did injury take place? \_\_\_\_\_

Did you file a claim for compensation and receive Worker's Compensation benefit payments?  Yes  No  
If "yes" please provide copies of your worker's compensation award.

Did you apply for Social Security Disability Insurance Benefits?  Yes  No

If "yes" when did you apply for Social Security Disability Insurance Benefits? \_\_\_\_\_, 20\_\_\_\_  
Month Year

Please provide a copy of your Social Security Disability application and all favorable and non-favorable decisions (if applicable).

I understand that in order to process my disability pension application, the Pension Fund may need to get additional information from me (or from a Contributing Employer or from Social Security). In that event, I understand that it may take longer than 90 days for the Fund to make a determination on my claim for benefits. I hereby consent to the extension of any time periods in the Plan for making benefit determinations until the Pension Fund receives all the necessary information. I have read Sections C, D, E, and F on the reverse side of this application.

**PENSIONER MUST SIGN HERE AFTER COMPLETING THIS APPLICATION**

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

## D. SOCIAL SECURITY AUTHORIZATION

**You must sign this authorization so we can verify you are approved to receive Social Security disability benefits.**

This is my application for a disability pension. I authorize the Social Security Administration to release information to the 1199SEIU Health Care Employees Pension Fund verifying my Social Security disability benefits.

I understand that the information the Social Security Administration provides may include verification of my Social Security number and any death indication. My consent allows no additional information to be provided from my Social Security records, and the information provided will be used solely for the purpose of determining eligibility to receive a disability pension from the 1199SEIU Health Care Employees Pension Fund.

I also understand that this authorization will remain in effect, on a continuing basis, while I am receiving benefits under the 1199SEIU Health Care Employees Pension Fund, unless and until revoked by me in writing.

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

***Your Disability Pension Benefit will be paid in an amount equal to the MONTHLY PENSION WITH NO SURVIVOR option.***

Your Disability Pension Benefit will usually start as of the effective date of your Social Security Disability payments. But you cannot receive a Disability Pension Benefit until after your weekly disability benefits from the 1199SEIU National Benefit Fund have ended.

Retroactive benefits are not paid for any time earlier than two years before you filed your application for Disability Pension Benefits with the Pension Fund.

You will continue to receive the Disability Pension Benefit up until age 65, as long as you continue to qualify for Social Security Disability payments. If your SSD Benefit ends, you must immediately inform the Pension Fund. **Once you reach age 65, your Disability Pension Benefit will stop and your Pension will be converted to a Normal Retirement Pension and you will have to elect one of the Post Retirement options as is required by the Plan. You will have to complete a pension application form, including spousal consent if applicable.**

When you apply for a Normal Retirement Pension (at age 65), or an Early Retirement Pension, you must select any one of the retirement options provided in the Plan and SPD. Should a married participant die prior to the normal retirement age (65), the spouse may be entitled to a qualified pre-retirement spouse survivor benefit in accordance with the provision of the Plan and SPD.



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## REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

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1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____	Social Security Number _____
Other Name(s) Used (Include Maiden Name) _____	Date of Birth (Mo/Day/Yr) _____

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2. What kind of information do you need?

- Detailed Earnings Information** For the period(s)/year(s): \_\_\_\_\_  
(If you check this block, tell us below why you need this information.)  
\_\_\_\_\_  
\_\_\_\_\_
- Certified Total Earnings For Each Year.** For the year(s): \_\_\_\_\_  
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement)
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3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. \$ \_\_\_\_\_

Do you want us to certify the information?  Yes  No

If yes, enter \$15.00 . . . . . B. \$ \_\_\_\_\_

ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. \$ \_\_\_\_\_

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
  - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
  - DO NOT SEND CASH.
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4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here  
(Do not print) > \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_  
(Area Code) (Telephone Number)

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5. Tell us where you want the information sent. (Please print)

Name \_\_\_\_\_ Address \_\_\_\_\_  
City, State & Zip Code \_\_\_\_\_

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6. Mail Completed Form(s) To: **Exception:** If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration  
Division of Earnings Record Operations  
P.O. Box 33003  
Baltimore Maryland 21290-3003

Social Security Administration  
Division of Earnings Record Operations  
300 N. Greene St.  
Baltimore Maryland 21290-0300

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