FRONT – RETIREE INFORMATION

LAST NAME	FIRST NAME	MID	FULL SOCIAL SEC #	PENSION #	Date of RETIRE	LAST ASSIGNED TO

ADDRESS:	CITY	STATE	ZIP	DATE OF BIRTH	APPT DATE

HOME PHONE #:	CELL PHONE #:	EMAIL ADDRESS	DENTAL PLAN (Check One) ☐ HealthPlex (UFA Reimbursement Plan) ☐ DENTCARE

CURRENT MARITAL STATUS	☐ SINGLE	☐ DOMESTIC PARTNER	☐ MARRIED	☐ LEGALLY SEPARATED	☐ DIVORCED	☐ WIDOWED
DATE OF EVENT (MONTH / DAY / YEAR)	X X X	/ /	/ /	/ /	/ /	/ /

SPOUSE (or DOMESTIC PARTNER) INFORMATION

FIRST NAME	MIDDLE	LAST NAME (AS IT APPEARS ON SOCIAL SECURITY CARD)	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH / /

FULL SOCIAL SEC #:	EMPLOYMENT STATUS ☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED Name of Employer (if EMPLOYED or RETIRED)________________________	ADDRESS OF EMPLOYER (IF EMPLOYED OR RETIRED)

DEPENDENT INFORMATION

LIST YOUR YOUNG ADULT DEPENDENTS, UP TO AGE 26

NAME	SOCIAL SECURITY #	DISABLED?	CHECK	DATE OF BIRTH	EMPLOYED ?	Name of Employer	Benefits through Employer?
		Y / N	☐ SON ☐ DAUGHTER ☐ STEP-CHILD		Y / N		Y / N
		Y / N	☐ SON ☐ DAUGHTER ☐ STEP-CHILD		Y / N		Y / N
		Y / N	☐ SON ☐ DAUGHTER ☐ STEP-CHILD		Y / N		Y / N
		Y / N	☐ SON ☐ DAUGHTER ☐ STEP-CHILD		Y / N		Y / N

ARE YOU OR ANY DEPENDENT MEMBER OF YOUR FAMILY COVERED FOR HEALTH INSURANCE THROUGH ANOTHER POLICY? ☐ YES ☐ NO

IF YES, POLICY NAME__________________________________ ☐ INDIVIDUAL ☐ FAMILY GROUP #______________________

ADDRESS_____________________________________ CITY__________________ STATE_______ ZIP___________

CONTINUED - BENEFICIARY INFORMATION (OVER) ➔ ➔ ➔ DEC 2018

RETIRED SECURITY BENEFIT / DEATH BENEFIT

PRIMARY BENEFICIARY

LAST NAME	FIRST NAME	MID	SOCIAL SEC #	RELATIONSHIP TO YOU

ADDRESS:	CITY	STATE	ZIP	DATE OF BIRTH	PHONE NUMBER

If you wish to have more than one beneficiary, please use a separate sheet and break down into percentages. Questions? Call 212-683-4723 & press 2 for assistance.

SECONDARY (ALTERNATE) BENEFICIARY - in the event that your Primary Beneficiary Pre-Deceases (dies before) you.

LAST NAME	FIRST NAME	MID	SOCIAL SEC #	RELATIONSHIP TO YOU

ADDRESS:	CITY	STATE	ZIP	DATE OF BIRTH	PHONE NUMBER

COMPENSATION ACCRUAL FUND

I hereby name the following individual(s) to receive the benefits upon my death from the Compensation Accrual Fund of the UFA (**IF MARRIED, BY LAW MUST BE YOUR SPOUSE** – Unless a spousal waiver is requested. Call 212-683-4723 for more info)

PRIMARY BENEFICIARY

LAST NAME	FIRST NAME	MID	SOCIAL SEC #	RELATIONSHIP TO YOU

ADDRESS:	CITY	STATE	ZIP	DATE OF BIRTH	PHONE NUMBER

SECONDARY (ALTERNATE) BENEFICIARY – in the event that your Primary Beneficiary Pre-Deceases (dies before) you.

LAST NAME	FIRST NAME	MID	SOCIAL SEC #	RELATIONSHIP TO YOU

ADDRESS:	CITY	STATE	ZIP	DATE OF BIRTH	PHONE NUMBER

X X SIGN HERE ➔ PLEASE SIGN: ______________________________ DATE________________

SIGNATURE OF MEMBER DATE OF SIGNATURE

PLEASE RETURN TO: Uniformed Firefighters Association, Security Benefit Fund - 204 East 23rd Street, 3rd Floor, NY, NY 10010. Questions? Call 212-683-4723

SINGLE PAGE FORMAT – you can also fill out this form ELECTRONICALLY and securely ONLINE at www.ufanycbenefits.org

For REVIEW PURPOSES only.
THIS DOCUMENT is NOT VALID if submitted.