FRONT – ACTIVE MEMBER INFORMATION

LAST NAME	FIRST NAME	MID	FULL SOCIAL SEC #	GENDER ☐ MALE ☐ FEMALE ☐ OTHER_____	Date of APPOINT / /	COMPANY ASSIGNED TO

ADDRESS:	CITY	STATE	ZIP	DATE OF BIRTH / /	BADGE #

HOME PHONE #:	CELL PHONE #:	EMAIL ADDRESS	REFERENCE #

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
		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

BACK

BENEFICIARY INFORMATION - 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 - if 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

BENEFICIARY INFORMATION - 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 – if 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 PLEASE SIGN **SIGN HERE➔** ______________________________ 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

THIS CAN ALSO BE SUBMITTED ONLINE / ELECTRONICALLY – GO TO www.ufanycbenefits.org **SBF Staff:** Check here if his form has been scanned SBF database ☐ Init___

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