

CIR/SEIU CARD A INTERNS, RESIDENTS, AND FELLOWS — HHC HOSPITALS
APPLICATION FOR MEMBERSHIP IN CIR/SEIU

Please Print

Last Name (Surname)				First				M.I.	
Home Address						Apt. No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (M/D/Y)	
City						State	Zip Code	Country of Birth	
Hospital			Service/Department			PGY	Degree (circle one) MD DO DDS Other		
Home Number (include Area Code)		Email		Cell		Hospital Beeper No. and Pin			
Medical/Dental School				Social Security No.		DATE		Hospital Code (leave blank)	
I hereby accept membership in the COMMITTEE OF INTERNS AND RESIDENTS (CIR/SEIU), which I authorize to act for me as collective bargaining agent and representative and pledge to abide by the Constitution and By-laws.						SIGNATURE			

CIR/SEIU CARD B INTERNS, RESIDENTS AND FELLOWS — HHC HOSPITALS
AUTHORIZATION FOR DUES OR AGENCY FEE DEDUCTION

Please Print

Office Use Only	Title	Dist Code	Bud Code	Bud Line	Effective Date	Social Security No.				
Please print	Name					Hospital				
IMPORTANT...CHECK ONE BOX BELOW										
<input type="checkbox"/> NYC Health & Hospital Corp (Municipal Hospitals). Subject to the terms and conditions set forth in the Mayor's Executive Order, dated May 15, 1969, and in all amendments or supplements thereto hereafter issued, to which terms and conditions I consent and agree, I hereby authorize the City of New York to deduct in each regular payroll from my salary or wages union membership dues in the sum of 1.5% OF GROSS PAY effective the first day of employment under my individual contract and to pay over said sum to the Employee Organization Check-Off Committee described in such Order in payment of my dues in the above captioned employee organization, on condition that said employee organization through said committee pay to the City of New York all costs and expenses determined by the City of New York as incurred by the City in connection with carrying out the plan authorized by said Order. THERE SHALL BE NO CHANGE IN THE AMOUNT OF THE DUES DEDUCTION WITHOUT DUE PRIOR NOTICE TO THE UNDERSIGNED EMPLOYEE MEMBER. This authorization shall terminate and cease not later than five weeks (if I am a monthly or bi-weekly paid employee) or not later than three weeks (if I am a weekly paid employee) after the department or agency of the City of New York in which I am employed receives written notice from me revoking and cancelling the same.										
<input type="checkbox"/> I request non-member agency shop status.										
SIGNATURE						Date				

CIR/SEIU CARD C CIR/SEIU BENEFITS PLANS
BENEFITS ENROLLMENT CARD

Office Use Only Effective Date: _____
Please Print

Last Name (Surname)			First Name			M.I.	Social Security Number			
Address			Apt. No.	City		State	Zip Code			
Hospital where employed		Home Telephone		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced		Date of Marriage (M/D/Y)		Dental Plan Selection <input type="checkbox"/> Managed Dental Guard <input type="checkbox"/> Dental Guard Preferred		
Department		Mobile Telephone		<input type="checkbox"/> M <input type="checkbox"/> F	Visa Status		Date of Birth (M/D/Y)		Managed Dental Guard Provider Office #	
List below names of SPOUSE and UNMARRIED CHILDREN up to 26 years of age.										
Name (First Last)			Sex	Full Time student	Date of Birth (M/D/Y)		Managed Dental Guard Provider Office #			
Spouse:			<input type="checkbox"/> M <input type="checkbox"/> F							
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No						
UNLESS YOU SIGN AND DATE THIS CARD, IT IS INVALID.										
SIGNATURE							DATE			

CIR/SEIU CARD D CIR/SEIU BENEFITS PLANS
BENEFICIARY DESIGNATION CARD

Please Print

Last Name (Surname)			First Name			M.I.	Social Security Number			
List below the BENEFICIARY or BENEFICIARIES to whom benefits are to be paid in case of your death. If more than one beneficiary is named, payment will be made in equal shares unless you specify otherwise.										
BENEFICIARY 1										
Name (First Last)			Relationship	%	Primary/Contingency		Date of Birth (M/D/Y)			
Address			Apt. No.	City		State	Zip Code			
BENEFICIARY 2										
Name (First Last)			Relationship	%	Primary/Contingency		Date of Birth (M/D/Y)			
Address			Apt. No.	City		State	Zip Code			
BENEFICIARY 3										
Name (First Last)			Relationship	%	Primary/Contingency		Date of Birth (M/D/Y)			
Address			Apt. No.	City		State	Zip Code			
UNLESS YOU SIGN AND DATE THIS CARD, IT IS INVALID.										
SIGNATURE							DATE			