

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

Please Print

Effective Date: \_\_\_\_\_

Last Name (Surname)		First		M.I.
Home Address			Apt. No.	Sex <input type="checkbox"/> M <input type="checkbox"/> F
City		State	Zip Code	Country of Birth
Hospital	Service/Department		PGY	Degree (circle one) MD DO DDS Other
Home Phone (include Area Code)	Email	Cell (include Area Code)	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 — VOLUNTARY HOSPITALS  
AUTHORIZATION FOR DUES OR AGENCY FEE DEDUCTION

Please Print

Name	Social Security No.
Hospital	
IMPORTANT...CHECK ONE BOX BELOW	
<input type="checkbox"/> You are hereby authorized and directed to deduct each month my monthly membership dues from my wages or salary, and to remit all deductions so made to the Committee of Interns and Residents (hereinafter referred to as the CIR/SEIU), no later than the tenth day of each month immediately following the date of deduction or following the date provided in the collective bargaining agreement for such deduction. The authorization shall remain in full force and effect until the same is revoked by me in writing, copies of which revocation must be sent to the Hospital and to the CIR/SEIU unless the terms of the contract between the Hospital and the CIR/SEIU stipulate otherwise.	
<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 #
<b>List below names of SPOUSE and UNMARRIED CHILDREN up to 23 years of age.</b>			
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	
<b>UNLESS YOU SIGN AND DATE THIS CARD, IT IS INVALID.</b>			
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.			
<b>BENEFICIARY 1</b>			
Name (First Last)	Relationship	%	Primary/Contingency Date of Birth (M/D/Y)
Address	Apt. No.	City	State Zip Code
<b>BENEFICIARY 2</b>			
Name (First Last)	Relationship	%	Primary/Contingency Date of Birth (M/D/Y)
Address	Apt. No.	City	State Zip Code
<b>BENEFICIARY 3</b>			
Name (First Last)	Relationship	%	Primary/Contingency Date of Birth (M/D/Y)
Address	Apt. No.	City	State Zip Code
<b>UNLESS YOU SIGN AND DATE THIS CARD, IT IS INVALID.</b>			
SIGNATURE			DATE