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Application for CIR/SEIU Membership - NYC H+H

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Committee of Interns and Residents SEIUHealthcare

HOSPITAL NAME

Welcome to the Committee of Interns and Residents/SEIU! We are the largest housestaff union in the United States, representing over 14,000 resident physicians and fellows who are dedicated to improving residency training and education, advancing patient care, and expanding healthcare access for our communities.

Instructions: Use a black or blue ink pen and mark boxes like this: [X] Fill in bubbles like this: ●

Print in CAPITAL LETTERS like this: A B C D E

Status:

☐ New Member Hire Date: M M / D D / Y Y Y Y

If you were a CIR member before, which hospital: Previous CIR Hospital Name

For Office Use Only Add Number

Member Information:

Member's Last Name (Surname) First Name M.I.

Home Address Apt. No.

Gender: ○ Male ○ Female

Degree: ☐ MD ☐ DO ☐ DMD ☐ PhD ☐ DDS ☐ DPM ☐ MBBS ☐ MPH ☐ OTHER

City/Town State Zip Code

Date of Birth: M M / D D / Y Y Y Y PGY/RP Department

Indicate if you were (or are) a member of: ☐ AMSA ☐ SNMA ☐ LMSA ☐ SOMA ☐ AMA

Medical / Dental School Cell (Include Area Code)

Email (personal)

Membership Dues Authorization

Hospital Name: _____

I hereby authorize, 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, 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 and 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 5 weeks (if I am a monthly or bi-weekly paid employee) or not later than 3 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.

Residents that choose not to join CIR/SEIU will have an agency fee deducted from their salary in lieu of CIR/SEIU dues, but will not receive the rights of CIR/SEIU membership. Agency fee payers shall have the right to object to paying for CIR/SEIU expenses unrelated to collective bargaining and shall receive an annual notice instructing them how to raise an objection.

Dues and fees to CIR are not deductible as charitable contributions for federal income tax purposes. Dues and fees paid, however, may qualify as business expenses, and may be deductible in limited circumstances subject to various restrictions imposed by the Internal Revenue Service.

Signature X _____

Print Name Here First Last

Today's Date: M M / D D / Y Y Y Y

Social Security No. - Required ___ - __ - ____

Union Code: ZA ZB ZC ZD ZE ZF ZG ZH

IMPORTANT - Please Sign and Date Below to Confirm Membership:

I hereby request, and will accept, membership in the Committee of Interns and Residents (CIR). I, upon becoming a member, authorize CIR to act for me as collective bargaining representative and pledge to abide by its Constitution and By-Laws.

Signature X _____

Print Name Here First Last

Today's Date: M M / D D / Y Y Y Y

YES, I want to be an advocate for my patients. Sign me up to contribute to SEIU COPE.

Hospital Name: _____

I hereby authorize my employer to deduct ○ $5 ○ $10 ○ _____ from my bi-weekly paycheck, and transfer the funds as a voluntary contribution to SEIU COPE.

I understand that: 1) I am not required to sign this form or make SEIU COPE contributions as a condition of my employment by my employer or membership in the union; 2) I may refuse to contribute without any reprisal; 3) Only union members and executive/administrative staff who are U.S. citizens or lawful permanent residents are eligible to contribute to SEIU COPE; 4) The amounts on this form are merely a suggestion, and I may contribute more or less by this or some other means without fear of favor or disadvantage from the union or my employer; 5) SEIU COPE uses the money it receives for political purposes, including but not limited to addressing political issues of public importance and contributing to and spending money in connection with federal, state and local elections. Contributions to the SEIU COPE are not deductible for federal income tax purposes. This authorization shall remain in effect until revoked in writing by me and sent to CIR/SEIU Healthcare Local 1957 or my hospital's payroll office.

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Signature X _____

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House Staff Benefits Plan (HSBP)

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Place an X in any of the boxes below that apply:

Marital Status

○ Single ○ Married
○ Domestic Partner (DP) ○ Divorced

Date of Marriage

M M / D D / Y Y Y Y

Dental Selection Instructions

Under the dental plan selection area, indicate the dental plan you prefer. Managed Dental Guard is a low-cost, fixed plan with a network of participating providers. The Dental Guard Preferred Plan offers more providers but has higher out-of-pocket costs. If you do not select a dental plan, you will be defaulted to MDG and assigned a dental provider closest to your home zip code.

Dental Plan Selection

(If you or your dependents reside outside the tri-state area, you MUST elect DGP)

○ Managed Dental Guard(MDG)
○ Dental Guard Preferred (DGP)

Dependent Information

List below names of SPOUSE and UNMARRIED CHILDREN up to 29 years of age.

Your spouse and dependent children up to the age of 29 are eligible for benefits at no cost to you. If you wish to enroll your spouse, fill in your spouse's name, **social security number**, and attach a copy of your **marriage certificate.** To enroll your dependent children, please fill in his/her name, **social security number**, and attach a copy of their **birth certificate** (adoption or guardianship papers also acceptable). If you wish to enroll your domestic partner, please contact the Plan office at (212) 356-8180 to obtain a Domestic Partnership application.

WE WILL NOT BE ABLE TO PROVIDE BENEFITS TO YOUR ELIGIBLE DEPENDENTS WITHOUT THE REQUIRED DOCUMENTS.

	Name (First)	(Last)	(Mi)	Gender	Full Time Student	Date of Birth (MM/DD/YYYY)	Social Security No.
Spouse /DP				○ M ○ F		- -	- -
Child				○ M ○ F	○ Yes ○ No	- -	- -
Child				○ M ○ F	○ Yes ○ No	- -	- -
Child				○ M ○ F	○ Yes ○ No	- -	- -
Child				○ M ○ F	○ Yes ○ No	- -	- -

CIR/SEIU Benefits Plan Beneficiary Designation

Insert name and address of person(s) to whom your life insurance is to be paid. Specify their relationship to you, what percentage of your life insurance they should receive, and include their date of birth and address.

BENEFICIARY 1

Name (First) (Last) (Mi) % Relationship Date of Birth (MM/DD/YYYY)

Address Apt. No. City State Zip

International Address - Street City/Town/Locality Postal Code Country

BENEFICIARY 2

Name (First) (Last) (Mi) % Relationship Date of Birth (MM/DD/YYYY)

Address Apt. No. City State Zip

International Address (Street) City/Town/Locality Postal Code Country

Your CIR/SEIU contract provides many benefits for you and your dependents AT NO COST TO YOU. Complete this enrollment with all SS numbers and supporting documents and you and your dependent(s), if applicable, will be automatically enrolled in these benefits for FREE!

1) Accidental Dismemberment
21 Childcare Benefit
3) Continuing Learning Program
4) Dental Coverage - Two options
5) Dental Reimbursement
6) Hearing Aid
7) Identity Theft Protecting
8) Legal Services Benefit (CIRLS)
9) Life Insurance
10) Long-Term Disability
11) Major Medical Reimbursement
12) Newborn Reimbursement
13) Obstetrical Reimbursement
14) Mental Health Reimbursement
15) Online Language Benefit
16) Professional Education Plan
17) Prescription Drug Benefit
18) QI Patient Safety Programs
19) QI Scholarship Programs
20) Short Term Disability
21) Substance Abuse Benefit
22) Transgender Benefit
23) Vision

BENEFIT FUNDS
CIR
Committee of Interns and Residents
SEIUHealthcare*

For more, information, contact the CIR/SEIU Benefits Office
Phone: (212) 356-8180, Monday-Friday, 9am - 5pm EST
Email: benefits@cirseiu.org Fax: (212) 356-8181
Address: 520 Eighth Avenue, Suite 1200, New York, NY 10018
Website: www.cirseiu.org/benefits

By signing this form, I certify that all information provided above is complete and accurate to the best of my knowledge. I understand that failure to provide complete and accurate information including supporting documentation may result in the delay or denial of benefits. Furthermore, I understand the benefits provided by completing this form are subject to modification by the Plan to insure compliance with applicable laws, and any other changes the Plan deems necessary.

Member's Signature X _____

Today's Date: M M / D D / Y Y Y Y

First **Last**

IF YOU DO NOT COMPLETE, SIGN AND DATE THIS FORM IT WILL BE RETURNED TO YOU

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