



Membership Affiliation: Boston Marine Transport

AUTHORIZATION AND APPLICATION FOR MEMBERSHIP



To The Officers and Members of:

DISTRICT NO. 1-PCD, M.E.B.A. (AFL-CIO) of the NATIONAL MARINE ENGINEERS' BENEFICIAL ASSOCIATION (AFL-CIO)

I hereby apply for membership in the District No. 1-PCD, M.E.B.A. (AFL-CIO).

I do hereby authorize and designate the union, District No. 1-PCD, M.E.B.A. (AFL-CIO) as my sole collective bargaining representative to represent me and, on my behalf, to negotiate and conclude all agreements as to wages, hours of labor, and other employment conditions.

It is understood that the Union has the absolute right to reject or terminate this Application at any time prior to my admission as a member into the Union. I also understand that in the event I voluntarily terminate my applicant status or I am dropped from applicant status due to non-payment of initiation or service fees, I shall not be entitled to any refund or reimbursement of such initiation or service fees.

I understand and agree that it shall be exclusively my obligation to notify the Union in writing when I have fulfilled the requirements for membership as set forth in the Constitution, By-Laws, Rules and Regulations of the Union, and any applicable Application Information Fact Sheet which are available upon request.

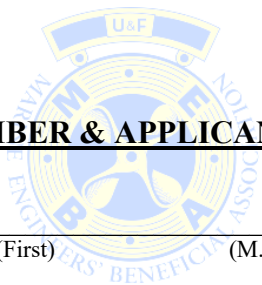
Pending my admission as a member into the Union, I shall be obligated to pay to the Union a service fee equal to what is being paid by members of their dues and I shall be entitled to exercise and enjoy only such rights and privileges (including shipping rights) as may be accorded to me under the outstanding Constitution, By-Laws, Rules, Regulations of the Union, and any applicable Application Information Fact Sheet.

It is further understood and agreed that the processing of my application for membership is subject to and conditioned upon the Constitution, By-Laws, Rules and Regulations of the Union and any applicable Application Information Fact Sheet covering such subject.

(Print Name of Applicant)

(Signature of Applicant)

(Date)



M.E.B.A. MEMBER & APPLICANT DATA SHEET

Name: _____ **Gender (M/F):** _____
(Last) (First) (M.I)

(Social Security Number) (Home Phone Number)

(E-mail address) (Cell Phone Number)

Address of Record:

(Street Address) (City, State) (Zip)

Mailing Address: (If same as address of Record put "same")

(Street Address) (City, State) (Zip)

Document Information:

(Current MMC Endorsements)

(Endorsements continued) (Reference Number) (MMC Expiration)

(TWIC Number) (TWIC Expiration)

(Passport Number) (Passport Expiration)

Next of Kin:

(Name: Last, First) (Relationship)

(Contact Address) (Phone Number)

Personal Information:

(Birth Date) (Birthplace: City/State/Country) (Date Naturalized, City)

(Height) (Weight) (Eye Color) (Hair Color)

(Status: Single, Married, Divorced) (Name of Spouse) (Number of Dependents)

I. PRIOR MEMBERSHIP

Have you ever previously made application for M.E.B.A. membership? _____

If Yes, Where: _____ When: _____
(Branch) (Date of Application)

Prior Membership ___ Rejected ___ Dropped ___ Withdrawn

Have you ever been found guilty of charges or suspended from the shipping or night list in this Union? _____. If Yes, explain reason: _____

II. PRESENT/PRIOR EMPLOYMENT:

Have you ever been employed as a licensed marine officer on U.S. flag vessels not working under a contract to District No. 1 – PCD, MEBA? _____
(Yes or No)

If Yes, supply information covering ALL such employment (use separate sheet if necessary):

COMPANY/UNION	SHIP	RATING	FROM	TO
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all Employment in the last three (3) years not listed above (use separate sheet if necessary)

COMPANY	CITY/STATE	POSITION	FROM	TO
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

III. EDUCATION

Are you a Maritime Academy graduate? _____
(Yes or No) (Academy) (Graduation Date)

(If no, then what is the Highest Level of Education for which you have received a diploma?)

(Name of School; City, State and Year Graduated)

IV. UNION AFFILIATIONS (Check here if none ___)

Present Union Affiliations (Refer to Obligation for other licensed marine officers' organizations):

Name _____ Status _____
(Present Union and Local) (Member, Applicant, Journeyman, Apprentice)

Former Union Affiliations Other Than District No. 1 – PCD, MEBA:

Name _____ Status _____
(Former Union and Local) (Suspended, dropped, expelled, withdrew)



DISTRICT NO. 1-PCD, M.E.B.A. (AFL-CIO) INITIATION FEE AGREEMENT

I understand and agree that as an Applicant for Membership in District No. 1 – PCD, M.E.B.A., I will pay the membership Initiation Fee in accordance with the terms and conditions set forth below:

1. I hereby agree that upon accepting employment through the offices of District No. 1 – PCD, M.E.B.A. as a licensed officer, I will pay the sum of \$160.00 per month, each month, until the total sum of \$4,000 is paid. As an unlicensed applicant I will pay \$100 per month each month until the total sum of \$2,500 is paid.
2. The first payment shall be due and owing thirty (30) days after I first accept employment through the offices of District No. 1 – PCD, M.E.B.A.
3. (a) I understand that payments toward my Initiation Fee that become due and owing will be paid at the rate of \$160 a month for 25 months for a total of \$4,000 for licensed officers and \$100 a month for 25 months for a total of \$2,500 for unlicensed applicants.

(b) Authorization for these deductions has been given by me on appropriate forms that were provided with my Application for Membership.
4. I understand that if my Initiation Fee is not paid in full within a 25-month period commencing when I first accept employment through the office of District No. 1-PCD, M.E.B.A., I will be obligated to complete payment of the outstanding balance of my membership Initiation Fee within thirty (30) days.

I further understand I will forfeit any monies paid toward my membership Initiation Fee if I do not comply with all the provisions of this Agreement.

Signature of Applicant

WITNESS:

Date



BOSTON MARINE TRANSPORT, INC. INFORMATION FACT SHEET

ATTACHMENT TO THE APPLICATION FOR MEMBERSHIP FOR THOSE APPLICANTS APPLYING FOR MEMBERSHIP UNDER THE PROVISIONS OF THE RULES AND REGULATIONS OF BOSTON MARINE TRANSPORT, INC. OF DISTRICT NO.1–M.E.B.A. (AFL-CIO).

Your application for membership in District No. 1- M.E.B.A. (AFL-CIO) will be accepted under the provisions of the District's Organizing Program, established for Boston Marine Transport, Inc., under the following conditions:

1. You are employed as a Licensed Marine Officer or in an unlicensed capacity on vessels under contract to Boston Marine Transport, Inc.
2. You must complete the proper Authorization and Application for Membership. Said Application should be reviewed and witnessed by an Official of the District and filed with District Headquarters.
3. You agree to pay the regular service charge quarterly in advance during the period of your applicant status. The current quarterly service charge is \$150.00 per quarter. You agree to pay the regular initiation fee of \$4,000.00 for licensed officers and \$2,500.00 for unlicensed payable over a twenty-five month period.
4. The District Investigating Committee will review your Applications for Membership. At the time you apply for membership, you must submit payment of one quarter's service charge. If the District Investigating Committee, at its discretion, rejects your application, you will be so notified and your service charge payment will be refunded.
5. Upon acceptance of your Authorization and Application for Membership, you will be classified as an Applicant for Membership under the District's Program for Boston Marine Transport, Inc., and you will automatically be granted a Group III Shipping Card. A Group III Shipping Card will be issued at the time your Applicant Book is issued. Proper application for your Applicant Book may be made at any District No. 1 – M.E.B.A. (AFL-CIO) Branch Office.
6. When you have completed two years of service working under Boston Marine Transport, Inc. contract either in a licensed or in an unlicensed capacity, paid the initiation fee in full as specified in this agreement, and complete two years (Eight quarters) service charge payments, you may apply for a Group II shipping status subject to availability of openings in Group II. At the same time, you should verify your employment aboard the vessels under contract to Boston Marine Transport, Inc. and submit same to the District Investigating Committee (DIC). This also may be done at any District Branch Office.

The DIC meets from time to time and your application will be reviewed in turn and in accordance with the requirements contained in this fact sheet and further subject to all the requirements of all Deep Sea applications for members unless modified herein. The DIC will then issue a report with its recommendations to the members to vote on at their regular monthly membership meetings.

7. If you are advised of your acceptance as a member of District No. 1 – M.E.B.A. (AFL-CIO), you may then apply for your Membership Book. This and any application for a renewal or a change in group shipping card may also be made at any District No. 1 M.E.B.A. branch office.

Note: Membership and group shipping cards are not the same.



WITHHOLDING AUTHORIZATION FOR M.E.B.A. POLITICAL ACTION FUND (PAF) CONTRIBUTIONS

I authorize my employer, _____ to withhold my
monthly contribution of:

\$25.00 \$50.00 \$100.00 _____% Other \$ _____

from my earnings in order to make political contributions to the M.E.B.A. Political Action Fund ("PAF"), 444 North Capitol Street, N.W., Suite 800, Washington, D.C. 20001.

I am sending a one-time donation via check or money order in the amount of \$ _____

This Authorization is voluntarily made based on my specific understanding that:

1. Signing of this Authorization and the making of these voluntary contributions are not conditions of membership in or of employment through the M.E.B.A.;
2. The figures above are mere suggestions, and I am free to contribute more or less than these guidelines;
3. I may refuse to contribute without reprisal;
4. The M.E.B.A. PAF, which is connected with the M.E.B.A., will use the voluntary contributions it receives for political purposes, including but not limited to making contributions to and expenditures for candidates for federal, state and local offices;
5. Contributions of gifts to the M.E.B.A. PAF are not deductible as charitable contributions for federal income tax purposes;
6. Federal law requires political committees to report to the Federal Elections Commission the name, mailing address, occupation and the name of employer for each individual whose contributions aggregate in excess of \$200.00 in a calendar year;
7. Washington State law prohibits an employer or other person from withholding a portion of a resident's earnings in order to make contributions to a political committee that must report to the Public Disclosure Commission or to a candidate or state or local office without written permission from that individual; and
8. I may revoke this Authorization at any time.

Printed Name: _____ Date: _____

Mailing Address: _____

Occupation: _____

Signature: _____



DISTRICT NO. 1-PCD, M.E.B.A. (AFL-CIO)
OBLIGATION & VOLUNTARY
RELINQUISHMENT

I, of my own free will and accord, do hereby solemnly and sincerely promise, swear and affirm that I will never impart any internal documents, contracts, proceedings of any meetings or any other verbal or written information deemed confidential or proprietary of the District No. 1 – PCD, M.E.B.A. (AFL-CIO) to any person not duly and justly qualified to receive same. I also bind myself not to join or belong to any other organization of licensed marine officers while I am a member or an applicant of this Organization. I also will not accept any employment outside of the M.E.B.A. utilizing my marine officer license without the permission of the Union in accordance with the M.E.B.A. By-Laws and Shipping Rules. I will faithfully obey and use my earnest endeavors to carry out the provisions of the Constitution, By-Laws, Shipping Rules and Regulations of the National Marine Engineers' Beneficial Association (AFL-CIO) and of this Organization and its Affiliates.

I have carefully read and signed the Obligation of my own free will and accord. It being understood that it in no way will interfere with my Social, Political or Religious rights.

Further, I understand that as an M.E.B.A. applicant, I will voluntarily relinquish any job received through this organization if I fail to become an elected member of this organization within the required time.

(Signature of Applicant)

(Date)

(Print Name of Applicant)

(Social Security Number)

(Witness)



Non-Discrimination Notice

The Marine Engineers' Beneficial Association (M.E.B.A.) does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. These activities include, but are not limited to, applying for membership in M.E.B.A., membership in M.E.B.A., hiring and firing of staff, selection of volunteers and vendors, and provision of services. We are committed to providing an inclusive and welcoming environment for all members of our staff, clients, volunteers, subcontractors, vendors, and clients.

M.E.B.A. is an equal opportunity employer. We will not discriminate and will take affirmative action measures to ensure against discrimination in membership, employment, recruitment, advertisements for employment, compensation, termination, upgrading, promotions, and other conditions of employment against any employee or job applicant on the bases of race, color, gender, national origin, age, religion, creed, disability, veteran's status, sexual orientation, gender identity or gender expression.

Instructions for Completing Permanent Data Forms

You must complete a Permanent Data Form if you are a new Participant, if you are adding a Dependant, if your marital status changes, or if your dependant's eligibility status changes.

The following documents must be included with your completed Permanent Data Form:

Married

- If you are married – a copy of your marriage certificate.

Children

- Biological children – a copy of each child's birth certificate.
- Adopted children – a copy of each child's adoption papers and birth certificate.
- Stepchildren – a copy of each child's birth certificate, a copy of your most recent IRS tax filing, a copy of that part of your spouse's divorce decree that assigns responsibility for the stepchild's medical care.
- Grandchildren - a copy of each child's birth certificate, proof of legal custody awarded by a court or state agency, a copy of your most recent IRS tax filing, (additional documentation may be required).

Dependant Parents

- Dependant Parents – a copy of your most recent IRS tax filing as proof that you claim your parent as a dependant on your tax return. You will be required to provide proof of support of your parent(s) annually.

Your parent(s) may be covered as a dependant only if:

- (1) you do not have a spouse, you do not have natural or adopted children under the age of 26, and you do not have stepchildren under age 19 (or 23, if full-time students); and
- (2) you contribute at least one-half of the support of the parent being claimed as a dependant, claim your parent as a dependant on your IRS tax return, and you submit a copy of your most recent IRS tax filing as proof of support.

Additional Requirements for Adult Children (over age 18)

Biological and Adopted Children Age 19 through 25

- Your biological and adopted adult children under the age of 26 may be covered as a dependant provided they are **not** eligible for other employment based coverage (other than parent's coverage). Employment based coverage is coverage that an adult child is eligible for due to the employment of the child or the child's spouse, regardless of whether the child enrolls in such coverage.
- You are required to verify the availability of employment based coverage for each biological and adopted adult child each year.

Stepchildren and Grandchildren

- Your stepchildren and grandchildren age 19 through age 22 may be covered as a dependant provided they are full-time students.
- Student status forms are available from the Plan Office or on the Plan website (www.mebaplans.org).
- You are required to verify full-time student status for each stepchild and/or grandchild each year.

Change in Marital Status

Marriage

- If you are single and become married, you must notify the Plan Office and submit a copy of your marriage certificate with your new Permanent Data Form to enroll your new spouse.

Divorce or legal separation

- If you are married and become divorced or legally separated, you must notify the Plan Office immediately and submit a copy of your divorce decree, legal separation agreement or your written agreement to live separately within 30 days, along with your new Permanent Data Form.
- If you are divorced and are keeping your children as dependants in the Plan, you must provide additional information about other coverage the children may have, such as through your former spouse (or his or her new spouse, if remarried), so that the Plan can properly coordinate benefits. If included in your divorce decree, a copy of the portion that assigns responsibility for medical care may be needed to determine order of payment.

Address and Address Changes

- If you use a PO Box as either your permanent address or your mailing address, you must also provide a physical address.
- If you are advising the Plan of a change of address only and have no other changes to make you can complete a new Permanent Data Form or you can simply notify the Plan Office in writing of the address change. Include your name and social security number. The Participant must sign this notification in order to allow the Plan Office to change your address.

IMPORTANT - When Coverage Terminates

If you and/or your dependant no longer meet the eligibility requirements your coverage and/or your dependant's coverage will end. You are required to notify the Plan Office in writing and within 30 days of events that impact your and/or your dependant's eligibility under the Plan. Events that may lead to ineligibility and a loss of coverage under the Plan include, but are not limited to:

- Failure to report a divorce;
- Failure to report a legal separation;
- Failure to report a child's eligibility for other coverage, including the availability of such coverage;
- For stepchildren and grandchildren, failure to report a change in student status, a change in residency or a change in support;
- For stepchildren and grandchildren, failure to report a child's marriage;
- For grandchildren, failure to meet the grandchild eligibility rules; and
- Failure to pay any required premiums (e.g., COBRA, pensioner contributions, Alternate Plan premiums) timely.
- For Pensioners, return to work under certain circumstances without the permission of the Trustees.

If you do not timely notify the Plan Office of an event that causes a change in your or your dependant's eligibility under the Plan, you will be required to reimburse the Plan for benefits that were paid after your and/or your dependant's coverage terminated.

In addition, your or your dependant's coverage under the Plan may be terminated retroactively in the case of fraud or intentional misrepresentation.

PERMANENT DATA FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name			
	Last Name	First Name	Initial
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	<input type="radio"/> Male <input type="radio"/> Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	<input type="radio"/> District No. 1-PCD, MEBA <input type="radio"/> Plan Employee <input type="radio"/> Union Employee <input type="radio"/> Other:		
Active/Pensioner (Check One)	<input type="radio"/> Active <input type="radio"/> Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Legally Separated		
Date Married, Widowed, Divorced or Legally Separated (mm/dd/yyyy)		<input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Legally Separated	
Permanent Address (Home of Record):	Number & Street		
	City, State, Zip		
Mailing Address (if different than Permanent Address above):	Number & Street		
	City, State, Zip		

**DEPENDANTS TO BE ADDED TO YOUR MEDICAL COVERAGE
(LIST FULL NAMES)**

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
					<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Adopted Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild	<input type="radio"/> Yes <input type="radio"/> No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) <input type="radio"/> Yes <input type="radio"/> No						
If eligible for Employment Based Coverage, complete the following sections						
Child's Employer Name		Child's Employer Address		Child's Employer Phone		
Child's Spouse's Employer Name		Child's Spouse's Employer Address		Child's Spouse's Employer Phone		

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
					<input type="radio"/> Child <input type="radio"/> Adopted Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild	<input type="radio"/> Yes <input type="radio"/> No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) <input type="radio"/> Yes <input type="radio"/> No If eligible for Employment Based Coverage, complete the following sections						
Child's Employer Name			Child's Employer Address		Child's Employer Phone	
Child's Spouse's Employer Name			Child's Spouse's Employer Address		Child's Spouse's Employer Phone	

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
					<input type="radio"/> Child <input type="radio"/> Adopted Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild	<input type="radio"/> Yes <input type="radio"/> No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) <input type="radio"/> Yes <input type="radio"/> No If eligible for Employment Based Coverage, complete the following sections						
Child's Employer Name			Child's Employer Address		Child's Employer Phone	
Child's Spouse's Employer Name			Child's Spouse's Employer Address		Child's Spouse's Employer Phone	

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
					<input type="radio"/> Child <input type="radio"/> Adopted Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild	<input type="radio"/> Yes <input type="radio"/> No
If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) <input type="radio"/> Yes <input type="radio"/> No If eligible for Employment Based Coverage, complete the following sections						
Child's Employer Name			Child's Employer Address		Child's Employer Phone	
Child's Spouse's Employer Name			Child's Spouse's Employer Address		Child's Spouse's Employer Phone	

(Attach a separate sheet to your Permanent Data Form if you have more than four Dependants)

Signature of Employee		Date	
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**FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.**

Instructions for Completing Beneficiary Designation Form

You must complete a Beneficiary Designation Form if you are a new Participant in the Plan or if you are changing your beneficiary for life insurance.

Changing Your Beneficiary for Life Insurance

- A new Beneficiary Designation Form must be completed in its entirety.
- The Beneficiary Designation Form **must be signed** for the change of beneficiary to become effective.

**MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (6322) * 410-547-6665 (Fax) * www.mebaplans.org**

BENEFICIARY DESIGNATION FORM

COMPLETE BOTH PAGES OF THIS FORM, SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name			
	Last Name	First Name	Initial
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	<input type="radio"/> Male <input type="radio"/> Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	<input type="radio"/> District No. 1-PCD, MEBA <input type="radio"/> Plan Employee <input type="radio"/> Union Employee <input type="radio"/> Other:		
Active/Pensioner (Check One)	<input type="radio"/> Active <input type="radio"/> Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Legally Separated		

BENEFICIARY DESIGNATION FORM

I designate the following person(s) as my beneficiary (ies) to receive benefits which may be payable from the MEBA Medical and Benefits Plan upon my death. I revoke all previous beneficiary designations and make the designation of beneficiary(ies) shown below with respect to benefits provided now or at any time in the future under the above Plan, still reserving to myself the privilege of making other and future changes subject to the Plan provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein (total must equal 100%). If no beneficiary survives me, settlement will be made in accordance with the provisions of the Plan. **NOTE: Co-beneficiaries receive proceeds in equal shares, unless otherwise indicated. Contingent Beneficiary is the person who will receive the proceeds if the primary beneficiary should predecease the person whose life is insured.**

Name: Check One:				
<input type="checkbox"/> Beneficiary <u>or</u>				
<input type="checkbox"/> Co-Beneficiary	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____ %
Date of Birth (mm/dd/yyyy)		Sex (Check One)	<input type="radio"/> Male <input type="radio"/> Female	

CO-BENEFICIARY (IES) OR CONTINGENT BENEFICIARY (IES)

Name: Check One: <input type="checkbox"/> Beneficiary <i>or</i> <input type="checkbox"/> Co-Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____ %
Date of Birth (mm/dd/yyyy)		Sex (Check One)	<input type="radio"/> Male	
			<input type="radio"/> Female	
Name: Check One: <input type="checkbox"/> Co-Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____ %
Date of Birth (mm/dd/yyyy)		Sex (Check One)	<input type="radio"/> Male	
			<input type="radio"/> Female	

Name: Check One: <input type="checkbox"/> Co-Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____ %
Date of Birth (mm/dd/yyyy)		Sex (Check One)	<input type="radio"/> Male	
			<input type="radio"/> Female	

(Attach a separate sheet to your Permanent Data Form if you have more than two Co-Beneficiaries)

Signature of Employee		Date	
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**FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.**

Union Members: *Know Your Rights*



U.S. Department of Labor
Washington, D.C. 20210

Office of Labor-Management Standards

The Labor-Management Reporting and Disclosure Act (LMRDA) guarantees certain rights to union members and imposes certain responsibilities on union officers to ensure union democracy, financial integrity and transparency. The Office of Labor-Management Standards (OLMS) is the Federal agency with primary authority to enforce many LMRDA provisions. If you suspect a violation of these rights or responsibilities please contact the Department of Labor at **1-866-4-USA-DOL**.

Union Member Rights

Bill of Rights - Union members have:

- equal rights to participate in union activities
- freedom of speech and assembly
- voice in setting rates of dues, fees, and assessments
- protection of the right to sue
- safeguards against improper discipline

Copies of Collective Bargaining Agreements -

Union members and nonunion employees have the right to receive or inspect copies of collective bargaining agreements.

Reports - Unions are required to file an initial information report (Form LM-1), copies of constitutions and bylaws, and an annual financial report (Form LM-2/3/4) with OLMS. Unions must make the reports available to members and permit members to examine supporting records for just cause. The reports are public information and copies are available from OLMS.

Officer Elections - Union members have the right to:

- nominate candidates for office
- run for office
- cast a secret ballot
- protest the conduct of an election

Officer Removal - Local union members have the right to an adequate procedure for the removal of an elected officer guilty of serious misconduct.

Trusteeships - Unions may only be placed in trusteeship by a parent body for the reasons specified in the LMRDA.

Protection for Exercising LMRDA Rights - A union or any of its officials may not fine, expel, or otherwise discipline a member for exercising any LMRDA right.

Prohibition Against Violence - No one may use or threaten to use force or violence to interfere with a union member in the exercise of LMRDA rights.

Union Officer Responsibilities

Financial Safeguards - Union officers have a duty to manage the funds and property of the union solely for the benefit of the union and its members in accordance with the union's constitution and bylaws. Union officers or employees who embezzle or steal union funds or other assets commit a Federal crime punishable by a fine and/or imprisonment.

Bonding - Union officers or employees who handle union funds or property must be bonded to provide protection against losses if their union has property and annual financial receipts which exceed \$5,000.

Labor Organization Reports - Union officers must:

- file an initial information report (Form LM-1) and annual financial reports (Forms LM-2/3/4) with OLMS.
- retain the records necessary to verify the reports for at least five years.

Officer Reports - Union officers and employees must file reports concerning any loans and benefits received from, or certain financial interests in, employers whose employees their unions represent and businesses that deal with their unions.

Officer Elections - Unions must:

- hold elections of officers of local unions by secret ballot at least every three years.
- conduct regular elections in accordance with their constitution and bylaws and preserve all records for one year.
- mail a notice of election to every member at least 15 days prior to the election.
- comply with a candidate's request to distribute campaign material.
- not use union funds or resources to promote any candidate (nor may employer funds or resources be used).
- permit candidates to have election observers.
- allow candidates to inspect the union's membership list once within 30 days prior to the election.

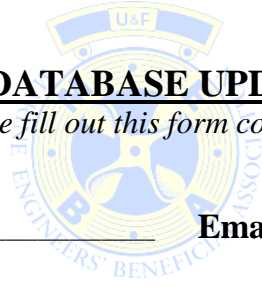
Restrictions on Holding Office - A person convicted of certain crimes may not serve as a union officer, employee, or other representative of a union for up to 13 years.

Loans - A union may not have outstanding loans to any one officer or employee that in total exceed \$2,000 at any time.

Fines - A union may not pay the fine of any officer or employee convicted of any willful violation of the LMRDA.

M.E.B.A. DATABASE UPDATE FORM

(Please fill out this form completely)



Date Completed: _____ **Email Address:** _____

Name: _____

(Last)

(First)

(M.I.)

(SSN – Last 4 Digits)

(Home Phone Number)

(Cell Phone Number)

(Mailing Address)

(City, State)

(Zip)

Highest Current Unlimited License

Steam	Motor	Gas Turbine	Deck	MMC Expiration Date: _____
Chief	Chief	Chief	Master	
1 AE	1 AE	1 AE	C/M	STCW Endorsement Expiration Date _____
2 AE	2 AE	2 AE	2 M	
3 AE	3 AE	3 AE	3 M	Mariner Reference Number: _____

If highest License is Limited, specify here: _____

Mark all certifications earned and date on certificate

<i>Engine/Deck</i>	ATO/SST - (3 year expiration)	_____
<i>Deck</i>	Basic MSC Refresher - (5 years)	_____
<i>Deck</i>	CBRD Officer – (5 years)	_____
<i>Engine</i>	CMEO - (Once)	_____
<i>Deck</i>	Crowd Control & Crisis Management – (Once)	_____
<i>Engine</i>	Damage Control/CBRD - (5 years)	_____
<i>Deck</i>	Drug Testing/Collection - (5 years)	_____
<i>Deck</i>	ECDIS - (Once)	_____
<i>Deck</i>	EKMS - (5 years)	_____
<i>Engine</i>	Engineer Resource Management - (Once)	_____
<i>Engine/Deck</i>	Helo Firefighting - (5 years)	_____
<i>Deck</i>	LAN Manager - (Once)	_____
<i>Engine/Deck</i>	Leadership & Management - (Once)	_____
<i>Engine/Deck</i>	Leadership & Teamwork - (Once)	_____
<i>Deck</i>	Marine Environmental Officer - (5 years)	_____
<i>Engine</i>	MEECE - (Once)	_____
<i>Engine</i>	Small Arms - (1 year)	_____
<i>Deck</i>	SST - (Once)	_____
<i>Engine/Deck</i>	STCW Basic Training – (5 years)	_____
<i>Engine/Deck</i>	STCW Tanker Familiarization - (5 years)	_____
<i>Engine/Deck</i>	Tankship DL - (5 years)	_____
<i>Engine/Deck</i>	Vessel Security Officer - (Once)	_____

LNG Vessel Experience? Yes No

Secret Security Clearance? Yes No