M.E.B.A. APPLICANT
Change of Bargaining Unit Affiliation

___Alaska State Ferry
___Boston Marine
___Cape May/Lewes Ferry
___Cargotec Port Engineers
___Chevron
___Connolly-Pacific
___Deep Sea
___Delaware Pilots
___DMC Marine (Donjon)
___FOSS
___GFC Crane Consultants
___Golden Gate Ferry
___Other _____

___Govt. Fleet – Army Corps of Engineers
___Govt. Fleet – Military Sealift Command (MSC)
___Govt. Fleet – NOAA
___Harbor Ferry Svcs-Empire Harbor
___Keystone Shipping/LDO
___Interlake Steamship
___Lamont Doherty
___Matson-Port Engineers
___POID
___Samson Tug & Barge
___Staten Island Ferry
___Washington State Ferry

To switch your bargaining unit affiliation, write "FR" in the appropriate slots above to indicate the bargaining unit you are leaving and "TO" to indicate the one to which you are going. Please complete and return this form to M.E.B.A. Headquarters, Attn: Membership Dept., 444 North Capitol Street, N.W., Suite 800, Washington DC 20001. Fax: (202) 638-5369. E-mail: membership@mebaunion.org

Applicants must include *a signed "Power of Attorney Form," "Initiation Fee Agreement," "Vacation Plan Authorization" form and the "Database Update Form." In addition, Members and Applicants changing affiliation to Deep-Sea must also include the completed Plans "Permanent Data" and "Beneficiary Designation" forms and the "Database Update Form." Deep Sea members changing affiliation to any other unit need to complete the one-page "Change of Bargaining Unit Affiliation" form as well as the "Database Update Form." Forms should be returned to M.E.B.A. HQ.*

I, _____ wish to change my bargaining unit affiliation from_____ to_____ effective _____.

This request is subject to all the rules, regulations, terms and conditions contained in the National M.E.B.A. Constitution, and the M.E.B.A. By-Laws, the Shipping Rules and the Rules and Regulations promulgated by the National Executive Committee and/or the District Executive Committee (DEC) currently in effect or as amended in the future.

Signed _____

Date _____

LIMITED POWER OF ATTORNEY FORM

BY THIS DOCUMENT, KNOW THAT

I, _____ Social Security No. _____ do hereby nominate, constitute and appoint Secretary-Treasurer Bill Van Loo, or his successor at District No. 1-PCD, Marine Engineers' Beneficial Association (AFL-CIO), 444 North Capitol Street, NW, Suite 800, Washington, DC 20001, my lawful attorney to act for me and in my place for the period of five (5) years from the date below, for the following specific purposes:

1. To open any envelope addressed to me care of District No. 1-PCD, M.E.B.A., 444 North Capitol Street, NW, Suite 800, Washington, DC 20001 whether delivered by hand or through the United States Mail or other commercial delivery service from the M.E.B.A. Vacation Plan and to take any check or checks made to my order by the M.E.B.A. Vacation Plan as payment of vacation benefits.

2. To endorse my name on such checks or checks for me and in my name from the M.E.B.A. Vacation Plan and to deposit such check in any bank account of District No. 1-PCD, M.E.B.A., for the credit of District No. 1-PCD, M.E.B.A.;

3. To deduct from the proceeds of such check or checks received from the M.E.B.A. Vacation Plan a sum equal in amount to the amount of initiation fee and/or vacation dues or service charge then due and owing from me to District No. 1-PCD, M.E.B.A. in accordance with the By-Laws of District No. 1-PCD, M.E.B.A. and its applicable rules and regulations;

4. To mail to me at the address specified on the M.E.B.A. Vacation Plan Authorization form a check from District No. 1 - PCD, M.E.B.A. in a sum equal to the balance remaining from the amount of the M.E.B.A. Vacation Plan check after making the appropriate deductions together with a written statement of account setting forth the amount of the M.E.B.A. Vacation Plan check, the amount deducted for dues or service charge and the balance remaining from the check and to mail to me a written statement of account, and the amount, if any, of dues or service charge still due and owing by me to District No. 1- PCD, M.E.B.A.

I hereby give and grant power of attorney to do and perform every act necessary to complete the acts referenced above as fully as I might or could do were I personally present, with full power of substitution, hereby ratifying and confirming all that my said attorney in fact shall lawfully do or cause to be done by virtue hereof.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _____ day of _____ 20____.

In presence of: _____

(Full Signature of Applicant)

FOR THE STATE OF:

COUNTY/PARISH/BOROUGH OF:

On this _____ day of _____, 20_____ before me personally appeared_____, to me personally known and known to me to be a person who executed the foregoing power of attorney and duly acknowledged that he/she executed the same. **(Affix Notary Public – Seal)**

_____

(Signature of Notary)

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. l – PCD, M.E.B.A., I will pay the membership Initiation Fee of $4,000.00 in accordance with the terms and conditions set forth below:

1. I hereby agree that upon accepting employment through the offices of District No. l – PCD, M.E.B.A., I will pay the sum of $160.00 per month, each month, until the total sum of $4,000.00 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. l – PCD, M.E.B.A.

3. I understand that payments toward my Initiation Fee that become due and owing will be deducted from the proceeds of my vacation benefits, in accordance with the policy and procedures set up by the District.

4. Authorization for these deductions has been given by me on appropriate forms that were provided with my Application for Membership.

5. 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

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

M.E.B.A. Vacation Plan Authorization

To: M.E.B.A. Vacation Plan
1007 Eastern Ave.
Baltimore, MD 21202

Attn: M.E.B.A. Vacation Plan Administrator:

For the period of five (5) years from the date below, please send to me any checks for vacation due me under the M.E.B.A. Vacation Plan for which I may from time-to-time file the appropriate vacation claim care of District No. 1 – PCD, M.E.B.A. (AFL-CIO), Suite 800, 444 N. Capitol Street, N.W., Washington, D.C., 2001,

Very Truly Yours,

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Social Security Number)

_____
(Address of Record)

_____
(City, State, Zip)

WITNESS_____

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.

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

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)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	☐ District No. 1-PCD, MEBA ☐ Plan Employee ☐ Union Employee ☐ Other:		
Active/Pensioner (Check One)	☐ Active ☐ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		
Date Married, Widowed, Divorced or Legally Separated (mm/dd/yyyy)		☐ Married ☐ Widowed ☐ Divorced ☐ 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
			☐ Spouse ☐ Child ☐ Adopted Child ☐ Stepchild ☐ Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐ Yes ☐ 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

Revised 12/2010

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
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐Yes ☐No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐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
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐Yes ☐No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐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
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐Yes ☐No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐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	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

Revised 12/2010

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)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	☐ District No. 1-PCD, MEBA ☐ Plan Employee ☐ Union Employee ☐ Other:		
Active/Pensioner (Check One)	☐ Active ☐ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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:** ○ Beneficiary ***or*** ○ 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)	○ Male ○ Female

Revised 12/2010

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

Name: **Check One:** ○ Beneficiary ***or*** ○ 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)	○ Male ○ Female	
Name: **Check One:** ○ Co-Beneficiary ***or*** ○ 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)	○ Male ○ Female	

Name: **Check One:** ○ Co-Beneficiary ***or*** ○ 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)	○ Male ○ Female	

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

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

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 <u>Unlimited</u> License

Steam	Motor	Gas Turbine	Deck
☐Chief	☐Chief	☐Chief	☐Master
☐1 AE	☐1 AE	☐1 AE	☐C/M
☐2 AE	☐2 AE	☐2 AE	☐2 M
☐3 AE	☐3 AE	☐3 AE	☐3 M

MMC Expiration Date: _____

STCW Endorsement Expiration Date _____

Mariner Reference Number: _____

If highest License is <u>Limited</u>, specify here:_____

Mark all certifications earned and date on certificate

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

LNG Vessel Experience? ☐Yes ☐No *Secret Security Clearance*? ☐Yes ☐No