



**Membership Affiliation: Connolly-Pacific**



**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, in 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.

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(Print Name of Applicant)

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(Signature of Applicant)

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(Date)



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

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

\_\_\_\_\_  
(Social Security Number) (Home Phone Number) (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)

\_\_\_\_\_  
(E-mail Address) (M.E.B.A. Book Number) (Book Issued: Mo/Day/Yr)

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

\_\_\_\_\_  
(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:

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

\_\_\_\_\_  
(Height) (Weight) (Eye Color) (Hair Color)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## 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, MEBA (AFL-CIO)  
INITIATION FEE AGREEMENT**

I understand and agree that as an Applicant for Membership in District No. I - PCD), MEBA, I will pay the Association's Initiation Fee of \$1,000.00 in accordance with the terms and conditions that are set forth below:

1. I hereby agree that upon accepting employment through the offices of District No. 1 - PCD, MEBA, I will pay the sum of \$40.00 per month, each month, until the total sum of \$1,000.00 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. I - PCD, MEBA.
3. I understand that if my Initiation Fee is not paid in full after the 25-month period, subsequent to my first date of employment, I will be obligated to complete payment of the balance due on such Fee within thirty (30) days after the completion of said 25-month period.

I further understand that I will forfeit any monies paid toward such Initiation Fee, if I do not comply with the above provisions of this Agreement.

\_\_\_\_\_  
Signature of Applicant

WITNESS:

\_\_\_\_\_  
Date

**POWER OF ATTORNEY**  
**KNOW ALL MEN BY THESE PRESENT, THAT**

I, \_\_\_\_\_ Social Security No. \_\_\_\_\_ do hereby nominate, constitute and appoint Bill VanLoo as Secretary-Treasurer or his successor of District No. 1-PCD, Marine Engineers' Beneficial Association (AFL-CIO), 444 North Capitol Street, NW, Suite 800, Washington, DC 20001, my true and lawful attorney in fact, for me and in my place and stead for the following and no other purposes for the period of five (5) years from the date here of:

1. To open any envelope addressed to me care of District No. 1-PCD, MEBA, 444 North Capitol Street, NW, Suite 800, Washington, DC 20001 and delivered by hand or through the United States Mail to District No. 1-PCD, MEBA by the MEBA Vacation Plan and to take there from any check or checks made to my order by MEBA Vacation Plan as payment of vacation benefits.
2. To endorse my name on such checks or checks for me and in my name, place and stead, and to deposit such check in any bank account of District No. 1-PCD, MEBA, for the credit of District No. 1-PCD, MEBA; and
3. To deduct from the proceeds of such check or checks 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, MEBA in accordance with the By-Laws of District No. 1-PCD, MEBA and its applicable rules and regulations; and
4. To mail to me at the address specified on the vacation application, a check from District No. 1 - PCD, MEBA to any order in a sum equal to the balance remaining from the amount of the said MEBA Vacation Plan check after making the aforesaid deductions together with a written statement of account setting forth the amount of the MEBA Vacation Plan check, the amount deducted for dues or service charge and the balance remaining, and if the deductions equal or are in excess of the said MEBA Vacation Plan check, to mail to me a written statement of account, and the amount, if any, of dues or service charge then still due and owing by me to District No. 1- PCD, MEBA after making the aforesaid deductions.

AND, I hereby give and grant unto my said attorney in fact full power and authority to do and perform every act necessary, requisite or proper to be done in and about the aforesaid premises 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 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, MEBA (AFL-CIO)**  
**VOLUNTARY RELINQUISHMENT OF JOB**

I, \_\_\_\_\_, understand, as an applicant for membership in the District No. 1- PCD, MEBA, will, since I am shipping on their contracted vessel, voluntarily relinquish any job received through this organization, if I fail to become an elected member of this organization within the required time.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

WITNESS \_\_\_\_\_

**DISTRICT NO. 1-PCD, MEBA (AFL-CIO)**  
**MEBA Vacation Plan Authorization**

To: MEBA Vacation Plan  
444 N. Capitol Street, NW  
Suite 800  
Washington, DC 20001

Dear Sir:

For the period of five (5) years from the date hereof, will you kindly send to me care of District No. 1 – PCD, MEBA (AFL-CIO), Suite 800, 444 N. Capitol Street, N.W., Washington, D.C., 2001, any checks for vacation due me under the MEBA Vacation Plan for which I may or may not from time to time file the appropriate vacation claim.

Very Truly Yours,

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Address of Record)

\_\_\_\_\_  
(City, State, Zip)

WITNESS \_\_\_\_\_

**DISTRICT NO. 1-PCD, MEBA (AFL-CIO)**  
**OBLIGATION**

I, of my own free will and accord, do hereby solemnly and sincerely promise, swear and affirm that I will never reveal any of the signs, grips or passwords, nor impart any of the business or proceedings of any meeting of the District No. 1 – PCD, MEBA (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 will faithfully obey and use my earnest endeavors to carry out the provisions of the Constitution, By-Laws, 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.

\_\_\_\_\_  
(Signature of Applicant) (Date)

\_\_\_\_\_  
(Print Name of Applicant) (Social Security Number)

Witness: \_\_\_\_\_



**DISTRICT NO. 1-PCD, MEBA (AFL-CIO)**  
**ACKNOWLEDGEMENT OF DUTIES**

1. Whereas the undersigned has made application for membership in District No. 1 – MEBA for the purpose of sailing as a licensed marine officer aboard merchant vessels; and

2. Whereas in addition to being an integral part of commerce and trade, the United States Merchant Marine plays an important part in carrying out the foreign policy of the United States Government; and

3. Whereas the Merchant Marine's role in carrying out foreign policy includes the transport of troops, munitions and other supplies for military forces of the United States and her allies to various parts of the world as required by the foreign policy:

LET IT BE KNOWN that the undersigned hereby acknowledges the above and further states that he will not refuse employment on a vessel, secured through the hiring hall of District No. 1 – PCD, MEBA carrying cargoes implementing American foreign policy as described in No. 3 above and will serve aboard vessels having such cargoes.

_____ (Print Name of Applicant)	_____ (Signature of Applicant)
_____ (Witness)	_____ (Date)
_____ (Signature of Parent or Legal Guardian)	
_____ (Print Name of Parent or Legal Guardian)	_____ (Relationship)

(In the event the Applicant is under the age of 21 years, this Agreement must be signed by one of the Parents of the Applicant or his Legal Guardian.)

**DISTRICT NO. 1-PCD, MEBA (AFL-CIO)**  
**Effective Date of Application**

To: DIC  
D1-PCD, MEBA (AFL-CIO)  
444 N. Capitol Street, NW  
Suite 800  
Washington, DC 20001

Dear Sirs:

I was an individual who through an immediate need of the Union was unable to complete the application before joining the MEBA contracted vessel,

\_\_\_\_\_ on \_\_\_\_\_ as \_\_\_\_\_.  
(Name of Vessel) (Mo/Day/Yr) (Position)

Attached find a copy of the dispatch for the vessel, a copy of the receipt for payment of the service fee from that quarter and a copy of the certificate of discharge for the vessel also showing completion of assignment. I request to have my Date of Application backdated to reflect the date of dispatch. I understand this is only effective for any assignments made after January 1, 2003.

Very Truly Yours,

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Social Security Number)

Union Official's Signature \_\_\_\_\_ SEAL  
(Verifying documents and Immediate Need)

**DISTRICT NO. 1-PCD, MEBA (AFL-CIO)**  
**APPLICANT IDENTIFICATION FORM**

The following information is requested with your Authorization and Application for Membership in order for District No. 1-PCD, MEBA (AFL-CIO) to be in compliance with the regulations issued by the Equal Employment Opportunity Commission under Title VII of the Civil Rights Act of 1964.

Please check the applicable boxes:

- |  |  |
|--|--|
| <input type="checkbox"/> Male                              | <input type="checkbox"/> Female                    |
| <input type="checkbox"/> White                             | <input type="checkbox"/> Black                     |
| <input type="checkbox"/> Hispanic                          | <input type="checkbox"/> Asian or Pacific Islander |
| <input type="checkbox"/> American Indian or Alaskan Native |  |
| <input type="checkbox"/> None of the above                 |  |

I understand that this form is for self-identification and will not be used for any other purpose than the filing of the required reports to the Equal Employment Opportunity Commission.

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(Signature of Applicant)

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(Witness)

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(Date)



**Employment Eligibility Verification**  
**Department of Homeland Security**  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** (*Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.*)

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States ( <i>See instructions</i> )
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. ( <i>See instructions</i> )  <i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i>  1. Alien Registration Number/USCIS Number: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 3. Foreign Passport Number: _____ Country of Issuance: _____
QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
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**Preparer and/or Translator Certification (check one):**

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





**Employment Eligibility Verification**  
**Department of Homeland Security**  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 08/31/2019

**Section 2. Employer or Authorized Representative Review and Verification**

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
<b>List A</b> Identity and Employment Authorization	<b>OR</b>	<b>List B</b> Identity	<b>AND</b>	<b>List C</b> Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

**Certification:** I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

**Section 3. Reverification and Rehires** (To be completed and signed by employer or authorized representative.)

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
Last Name (Family Name)		First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

<b>LIST A</b> <b>Documents that Establish Both Identity and Employment Authorization</b>	<b>OR</b>	<b>LIST B</b> <b>Documents that Establish Identity</b>	<b>AND</b> <b>LIST C</b> <b>Documents that Establish Employment Authorization</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</li> </ol> </li> </ol> </li> <li>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</li> </ol>		<ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of Birth Abroad issued by the Department of State (Form FS-545)</li> <li>3. Certification of Report of Birth issued by the Department of State (Form DS-1350)</li> <li>4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>5. Native American tribal document</li> <li>6. U.S. Citizen ID Card (Form I-197)</li> <li>7. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>8. Employment authorization document issued by the Department of Homeland Security</li> </ol>

**Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

**CONNOLLY-PACIFIC & DISTRICT NO. 1**  
**M.E.B.A. (AFL-CIO) FACT SHEET**

In consideration of the waiver by Connolly-Pacific and District No. 1-M.E.B.A. (AFL-CIO) of the requirements that the Connolly-Pacific initiation fee in the full amount of one thousand dollars (\$1000.00) to be paid together with this application for membership, I hereby agree to deposit with this application twenty-five percent (25%) of the full initiation fee in addition to the regular quarterly service fee of one hundred fifty dollars (\$150.00). I also agree to complete payment of the balance owed on the full initiation fee within one year from the date of my application and to continue to pay the regular service fee quarterly, in advance. If desired, the company will establish an automatic dues payment from the employee's paycheck upon receiving a dues authorization form.

I understand that in the event my application for membership be rejected, you will be so notified and your initial service charge payment/s will be refunded. I also understand that no guarantee of employment is either expressed or implied by the union and that once the application is accepted no refunds of initiation fees or service charges will be made.

Upon acceptance of your authorization and application for membership, you will be classified as an applicant for membership, Connolly-Pacific, District No. 1-M.E.B.A. (AFL-CIO). I further understand that I am not permitted to transfer out of Connolly-Pacific until such time as I become a full member of District No. 1, M.E.B.A.

If you elect to quit Connolly-Pacific, or your employment is terminated for reasons not related to Union activity prior to completing two years of service, and thereafter desire to obtain employment aboard vessels covered by other District agreements, you will then be required to file a new application.

The Union therefore expects that the applicant will complete the requirements set forth in the Connolly-Pacific, District No. 1-M.E.B.A. (AFL-CIO) program and any failure to complete the requirements will forfeit and void the authorization and the application made by you for membership.

I have read, understand, and agree to the above as witnessed by my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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Witnessed

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(Signature of Applicant)



## 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 by 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: \_\_\_\_\_



## **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](http://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
<b>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</b> <b>If eligible for Employment Based Coverage, complete the following sections</b>						
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
<b>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</b> <b>If eligible for Employment Based Coverage, complete the following sections</b>						
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
<b>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</b> <b>If eligible for Employment Based Coverage, complete the following sections</b>						
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
<b>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</b> <b>If eligible for Employment Based Coverage, complete the following sections</b>						
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 Dependents)

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.**



## **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.

# 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

Engine/Deck	ATO/SST - (3 year expiration)	_____
Deck	Basic MSC Refresher - (5 years)	_____
Deck	CBRD Officer – (5 years)	_____
Engine	CMEQ - (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	Engineer 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