DISTRICT NO. 1-PCD, MEBA

ECO-ALPHA CHECKLIST

TO BE COMPLETED BY AUTHORIZED UNION OFFICIAL

Applicant's Name: _____
Last First M.I.

Applicant's SSN: _____ Date of application: _____

Port of application: _____Union Official:_____

- Eco-Alpha Applicant Information Fact Sheet
- Member & Applicant Data Sheet
- Authorization and Application for Membership
- Obligation & Oath
- Applicant Identification Form
- MEBA Political Action Fund Authorization (optional)
- Current Service Fee receipt: Receipt No. _____
- Copy of completed application forms supplied to applicant, Original completed application forms sent to HQ.

ECO-ALPHA
Information Fact Sheet

ATTACHMENT TO THE APPLICATION FOR MEMBERSHIP FOR THOSE APPLICANTS APPLYING FOR MEMBERSHIP IN DISTRICT NO. 1 – PCD MARINE ENGINEERS' BENEFICIAL ASSOCIATION (M.E.B.A.) UNDER THE PROVISIONS ESTABLISHED FOR THE ECO-ALPHA ENVIRONMENTAL AND ENGINEERING SERVICES, INC. UNIT

Your application for membership in District No. 1 – PCD, Marine Engineers' Beneficial Association (M.E.B.A.), AFL-CIO will be accepted without payment of the Organization's initiation Fee ($4,000.00) under the following conditions:

1. You are employed under the District contract with Eco-Alpha.

2. You must complete the proper Authorization and Application for Membership. Said Application should be reviewed by an Official of the District and filed with District Headquarters.

3. You agree to pay the regular service charge through a dues/service charge check-off authorization. The current service charge is 2% gross straight time wages, comprising straight time wages, sick leave, vacation leave, and the straight time portion of holidays.

4. The District Investigating Committee (DIC) will review all Applications for membership. At the time you apply for membership, you must have executed, and included with the application, a dues/service charge check-off authorization. If the DIC, at its discretion, rejects your application, you will be so notified and the 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 the Eco-Alpha Unit.

6. Upon completion of twenty-four (24) months service working under the M.E.B.A. contract with Eco-Alpha and provided you have kept your dues/service charge check-off status current, you may request a review of your Application for Membership for admittance into the District as a full Member.

7. 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 Deep Sea Applications for membership 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.

8. Any Member or Applicant changing affiliation to the District's Deep Sea Sailing Unit will be required to pay, if not already paid, the full initiation fee of that unit, at the normal schedule (currently $4,000.00 over 25 months).

9. For the purposes of calculating group shipping status, days of covered employment at Eco-Alpha shall be at a 5/7^{ths} rate, similar to the Organization's Ready Reserve Fleet.

Initial:_____

MEBA MEMBER & APPLICANT DATA SHEET

Name: _____ **Nickname:** _____
(Last) (First) (M.I)

_____ _____ _____
(Social Security Number) (Home Phone Number) (Cell Phone Number)

Address of Record:

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

Mailing Address:

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

_____ _____ _____
(E-mail address) (MEBA Book Number) (Book Issued: Mo/Day/Yr

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

_____ _____ _____ _____
(Current License) (License Number) (Issue Number) (Expiration Date)

_____ _____
(MMD Endorsements) (MMD Expiration)

_____ _____
(STCW Endorsements) (STCW Expiration)

_____ _____ _____
(Passport Number) (Passport Expiration) (Original License Training Obtained)

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)

Membership Affiliation: Eco-Alpha

AUTHORIZATION AND APPLICATION FOR MEMBERSHIP

To The Officers and Members of:

DISTRICT NO. 1-PCD, MEBA (AFL-CIO)
of the
NATIONAL MARINE ENGINEERS'
BENEFICIAL ASSOCIATION (AFL-CIO)

I hereby apply for membership in the District No. 1-PCD, MEBA (AFL-CIO).

I do hereby authorize and designate the union, District No. 1-PCD, MEBA (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.

Initial:_____

Eco- Appl.

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. l – 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 and understand I will have breached this contract between myself and the Union should I belong to or join another Licensed Marine Officers Union. This aforementioned breach will cause my application to be null and void and I may not be re-considered for re–application or membership. 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 M.E.B.A. (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.

OATH

I swear or affirm that I do not believe in, nor am I a member of, nor do I support any organization that believes in or teaches or advocates the overthrow of the United States Government by force or by illegal or unconstitutional methods. I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without mental reservation or purpose of evasion. I swear or affirm that all the statements and information on this application are true.

Initial:_____

Recognition

I have read, understood, and agree to all of the provisions listed:

	Initial
Fact Sheet for Officers of Eco-Alpha	_____
MEBA Member & Applicant Data Sheet	_____
Authorization and Application for Membership	_____
Obligation	_____
Oath	_____

Signature: _____ Date:_____

ATTACHMENT

DUES CHECKOFF AUTHORIZATION FORM

I, the undersigned, hereby authorize my employer, Eco-Alpha, to deduct 2% of my straight-time wages (including all paid time-off, including, but not limited to: sick leave, vacation leave and holiday pay) as dues or agency fees, from my paycheck, on each pay period, and remit said amount, in a manner consistent with the Memorandum of Understanding to which my collective bargaining representative, District No. 1 – PCD, Marine Engineers Beneficial Association, AFL-CIO ("M.E.B.A.") and the aforementioned employer are parties, to the M.E.B.A, c/o Comptroller, M.E.B.A., District No. 1 – PCD, (AFL-CIO), 444 North Capitol Street, N.W., Suite 800, Washington, DC 20001.

This authorization shall be irrevocable for a period of one (1) year from the date I have signed this authorization, or until the termination of the afore-described Memorandum of Understanding, whichever comes first. I also agree and direct that this authorization shall be automatically renewed, and shall be irrevocable, for successive periods of one (1) year each, or for a period of each succeeding applicable labor agreement between the M.E.B.A. and my employer, whichever is shorter, unless written notice is given by me to my employer and to the M.E.B.A. not more than twenty (20) and not less than ten (10) days prior to the expiration of each period of one (1) year, or at expiration of each applicable collective bargaining agreement between the M.E.B.A. and my employer, whichever occurs sooner.

This authorization is made pursuant to Section 302 of the Labor Management Relations Act of 1947.

Signed: _____ Date: _____

Name (printed): _____

Address: _____

_____

_____

Email: _____

Phone: _____

Last 4 Digits of SSN: _____

POLITICAL
ACTION FUND

M.E.B.A. Political Action Fund
Marine Engineers' Beneficial Association
444 North Capitol Street, N.W.
Suite 800
Washington D.C. 20001

M.E.B.A.'s voluntary Political Action Fund (PAF) is a key tool that enables our Union to solidify the Union's political relationships in Congress. This is crucial for the continued viability of the U.S. Merchant Marine. We all benefit from a strong political advocacy program.

□ **Yes, I want to support the Political Action Fund (PAF) to promote the concerns of members through M.E.B.A.'s legislative and political activities.** I **hereby authorize and direct the M.E.B.A. Vacation Plan to deduct from my gross vacation earnings and remit to the M.E.B.A. PAF my voluntary contribution per month of:**

□ $10 □ $25 □ $50 □ $100 □___% □___Other

□ Instead, enclosed please find my check made payable to the M.E.B.A. PAF for $_____.

Name:_____ Signature:_____

Mailing Address_____

Date:_____ Social Security # (last 4 digits)_____

Email Address:_____ Cell #_____

You are free to contribute more or less than the suggested amounts above. PAF contributions are voluntary and not a condition of membership in or employment through the M.E.B.A. You may refuse to contribute without reprisal. The M.E.B.A.'s PAF will use voluntary contributions for purposes including, but not limited to, making contributions to and expenditures for candidates for federal, state, and local offices. Contributions to the PAF are not deductible as charitable contributions for federal tax purposes. Federal law requires political committees to report to the Federal Election Commission each individual whose contributions aggregate in excess of $200 in a calendar year. This authorization shall remain in full force and effect until revoked in writing by me to the Administrator of the M.E.B.A. Vacation Plan.

Voluntary Applicant Self-Identification Form

(Confidential - For Statistical Use Only)

We would appreciate it if you would take the time to complete this form, as part of our compliance requirements. M.E.B.A. is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, age, national origin, disability, veteran status, sexual orientation, or any other classification protected by federal, state, or local law.

The information below will be used only in the compilation of data for affirmative action reporting. Completion of this form is voluntary and will not affect your opportunity for employment or terms or conditions of employment. Identification can be declared at any time prior to, or, if applicable, after hire.

Gender

○ Male ○ Female

Race/Ethnicity

○ **American Indian/Native American or Alaskan Native** A person having origins in the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.

○ **Asian (not Hispanic or Latino)** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including Cambodia, China, Japan, Korea, India, Malaysia, Pakistan, Nepal, the Philippine Islands, Thailand, and Vietnam.

○ **Black or African** A person having origins in any of the black racial groups of Africa.

○ **Hispanic or Latino** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

○ **Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)** A person having origins in any of the peoples or Hawaii, Guam, Samoa, or other Pacific Islands.

○ **White (not Hispanic or Latino)** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

○ **Multiracial** A person whose biological parents are of different races.

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.

_____ _____

(Signature of Applicant) (Date)

_____ _____

(Witness name) (Witness signature)

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.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

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)*

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

STOP *Employer Completes Next Page* STOP

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.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** 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				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
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)*

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

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.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

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

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

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.

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

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.

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.