DISTRICT NO. 1-PCD, MEBA EQUILIEM CHECKLIST TO BE COMPLETED BY AUTHORIZED UNION OFFICIAL

Appli	cant's Name:
	Last M.I.
Appli	cant's SSN: Date of application:
Port o	f application:Union Official:
	Equiliem Applicant Information Fact Sheet
	Member & Applicant Data Sheet
	Authorization and Application for Membership
	Obligation & Oath
	Applicant Identification Form
	M.E.B.A. 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.



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 EQUILIEM 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 Equiliem.
- 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 Equiliem Unit.
- 6. Upon completion of twenty-four (24) months service working under the M.E.B.A. contract with Equiliem 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 Equiliem shall be at a 5/7^{ths} rate, similar to the Organization's Ready Reserve Fleet.

T .		
Init	10 l·	
ши	iai.	

MEBA MEMBER & APPLICANT DATA SHEET

Name:	27		Nickna	Nickname:				
(Last)	(First)	(M.I)						
(Social Security Number) Address of Record:	ENCIL	(Home Phone Number	45500	(Cell Pl	none Number)			
(Street Address)	~ ~	(City, State)	7		(Zip)			
Mailing Address:								
(Street Address)		(City, State)			(Zip)			
(E-mail address)		(MEBA Boo	k Number)	(Book l	Issued: Mo/Day/Yr			
(Birth Date)	(Birthpl	(Birthplace: City/State/Country)			(Date Naturalized, City)			
(Current License)		(License Nu	mber) (Is	sue Number	r) (Expiration Date)			
(MMD Endorsements)			(MMI	D Expiration	n)			
(STCW Endorsements)			(STC)	W Expiration	on)			
(Passport Number) Next of Kin:	(Passpo	rt Expiration)	(Origi	nal License	Training Obtained)			
(Name: Last, First)			(Relat	cionship)				
(Contact Address) Personal Information:				(Phone	Number)			
(Status: Single, Married, Divorced)	(Name o	of Spouse)		(Numbe	er of Dependents)			
(Height)		(Weight)	(Eye (Color)	(Hair Color)			

Membership Affiliation: Equiliem

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:_	
Equ	i 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. 1 – PCD, M.E.B.A. (AFL-CIO) to any person not duly and justly qualified to receive same. I also bind myself not to join or belong to any other organization of licensed marine officers while I am a member or an applicant of this Organization 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 reapplication 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.

	4
Initial	•
Initial	l.



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

		Initial
Fact Sheet for Officers of Equiliem		
M.E.B.A. Member & Applicant Data Sheet		
Authorization and Application for Membership		
Obligation		
Oath		
Signature:	Date:	



DUES CHECK-OFF AUTHORIZATION FORM

I, the undersigned, hereby authorize my employer, Equiliem, 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:		



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

solidify the viability of program. Yes, I concerns hereby au	e Union's pole f the U.S. Me want to s of member othorize and earnings and	itical relations erchant Marine upport the s through M direct the M	ships in Congr e. We all ben Political Act I.E.B.A.'s leg I.E.B.A. Vacat	ress. This is contesting the second s	rucial for trong pol PAF) to politica deduct f	s our Union to the continued litical advocacy promote the al activities. I rom my gross ntribution per
□ \$10	□ \$25	□ \$50	□ \$100	□ <u></u> %	□	_Other
	d, enclosed \$	please find	my check r	nade payab	le to the	e M.E.B.A.
Name:		Si	gnature:			
Mailing A	Address					
Date:		_ Social Sec	urity # (last 4	4 digits)		
Email Ad	ldress:			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.

Condo

Genuel		
O Male	O Female	
Race/Et	hnicity	
	an Indian/Native American or Alaskan Native A person America and who maintains cultural identification through	
		f the original peoples of the Far East, Southeast Asia, or the Indian Subcontinerstan, Nepal, the Philippine Islands, Thailand, and Vietnam.
O Black or	r African A person having origins in any of the black racia	al groups of Africa.
O Hispanio	c or Latino A person of Cuban, Mexican, Puerto Rican, S	outh or Central American, or other Spanish culture or origin, regardless of race
	Hawaiian or Other Pacific Islander (not Hispanic or La les or Hawaii, Guam, Samoa, or other Pacific Islands.	atino) A person having origins in any of
O White (r	not Hispanic or Latino) A person having origins in any o	f the original peoples of Europe, the Middle East, or North Africa.
O Multirac	cial A person whose biological parents are of different race	es.
	I that this form is for self-identification and will not be nt Opportunity Commission.	used for any other purpose than the filing of the required reports to the Equ
	(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 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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)	ame) Middle Initial (if any) Other La			Other Last	st Names Used (if any)		
Address (Street Number an	ot. Number (if	any) City or Towr	1			State	ZIP Code			
Date of Birth (mm/dd/yyyy)	U.S. So	cial Security Number	Emplo	yee's Email Addres	s			Employee	s's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or		1. A citizen c 2. A noncitiz 3. A lawful p 4. A noncitiz	heck one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): 1. A citizen of the United States 2. A noncitizen national of the United States (See Instructions.) 3. A lawful permanent resident (Enter USCIS or A-Number.) 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) you check Item Number 4., enter one of these:						:	
immigration status, is correct.	true and	USCIS A-Num	ber OR F	orm I-94 Admission	on Number	OR	eign Passpo	ort Number	r and Country of Issua	ance
Signature of Employee					Тс	day's Date	(mm/dd/yyy	y)		
If a preparer and/or tr	anslator assis	ted you in completir	ng Section 1,	that person MUST	complete t	the <u>Prepare</u>	er and/or Tra	anslator C	ertification on Page 3	
Section 2. Employer business days after the e authorized by the Secreta documentation in the Add	mployee's firs	st day of employme ocumentation from ation box; see Inst	ent, and mus List A OR a ructions.	t physically exam combination of d	ine, or exa ocumenta	amine con tion from L	sistent with List B and L	nd sign S o an altern ist C. En	ative procedure iter any additional	Э
		List A	OR	Lis	st B	-	AND		List C	
Document Title 1										
Issuing Authority										
Document Number (if any)										
Expiration Date (if any)										
Document Title 2 (if any)			Add	itional Information	on					
Issuing Authority										
Document Number (if any)										
Expiration Date (if any)										
Document Title 3 (if any)										
Issuing Authority										
Document Number (if any)										
Expiration Date (if any)			С	check here if you us	ed an altern	ative proce	dure authori		S to examine documen	ts.
Certification: I attest, unde employee, (2) the above-lis best of my knowledge, the	ted document	ation appears to be	genuine and	to relate to the em				First Da (mm/dd	y of Employment /yyyy):	
Last Name, First Name and	Title of Employe	er or Authorized Repro	esentative	Signature of Em	ployer or A	uthorized R	epresentativ	е	Today's Date (mm/dd/	/уууу)
Employer's Business or Organization Name Employer's Business or Organization Address, City or Town, State, ZIP Code										

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Form I-9 Edition 08/01/23 Page 1 of 4

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A		LIST B	LIST C				
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity ANI	Documents that Establish Employment				
U.S. Passport or U.S. Passport Card Permanent Resident Card or Alien Registration Receipt Card (Form I-551) Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machinereadable immigrant visa Employment Authorization Document that contains a photograph (Form I-766)		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 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 3. School ID card with a photograph	A Social Security Account Number card, unless the card includes one of the following restrictions:				
For an individual temporarily authorized to work for a specific employer because of his or her status or parole: Tousing pagenets and		4. Voter's registration card 5. U.S. Military card or draft record	FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal				
a. Foreign passport; and b. Form I-94 or Form I-94A that has the following:		Military dependent's ID card	authority, or territory of the United States bearing an official seal				
(1) The same name as the passport; and(2) An endorsement of the individual's status or parole as		 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority 	4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179)				
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.		For persons under age 18 who are unable to present a document listed above:	7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on				
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 card11. Clinic, doctor, or hospital record12. Day-care or nursery school record	uscis.gov/i-9-central The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.				
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.							
 Receipt for a replacement of a lost, stolen, or damaged List A document. Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.				

^{*}Refer to the Employment Authorization Extensions page on $\underline{\text{I-9 Central}}$ for more information.

Form I-9 Edition 08/01/23 Page 2 of 4



Last Name (Family Name) from Section 1.

Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security

U.S. Citizenship and Immigration Services

First Name (Given Name) from Section 1.

USCIS Form I-9 Supplement A OMB No. 1615-0047 Expires 07/31/2026

Middle initial (if any) from Section 1.

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.								
I attest, under penalty of perjury, that I have assisted i knowledge the information is true and correct.	n the	completion of Section 1 of tl	his form a	and that to	the best of my			
Signature of Preparer or Translator Date (mm/dd/yyyy)								
Last Name (Family Name) First Name (Given Name) Middle Initial (if any)								
Address (Street Number and Name)	•	City or Town		State	ZIP Code			

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			Date (mm	/dd/yyyy)	
Last Name (Family Name)	First I	Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town		State	ZIP Code

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			Date (mm	/dd/yyyy)	
Last Name (Family Name)	First I	Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town		State	ZIP Code

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			Date (mr	n/dd/yyyy)	
Last Name (Family Name)	First I	Name (Given Name)			Middle Initial (if any)
Address (Street Number and Name)		City or Town		State	ZIP Code

Form I-9 Edition 08/01/23 Page 3 of 4



Supplement B, Reverification and Rehire (formerly Section 3)

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9 Supplement B OMB No. 1615-0047 Expires 07/31/2026

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

	p this page as part of the e Guidance for Completing F		d. Additional guidance can b	e found in the_	
Date of Rehire (if applicable)	New Name (if applicable)				
Date (mm/dd/yyyy)	Last Name (Family Name)		First Name (Given Name)		Middle Initial
	ree requires reverification, you prization. Enter the documen		present any acceptable List A opelow.	or List C documenta	tion to show
Document Title		Document Number (if any)		Expiration Date (if an	y) (mm/dd/yyyy)
I attest, under penalty of employee presented doc	perjury, that to the best of umentation, the documenta	my knowledge, this emplo ition I examined appears t	yee is authorized to work in to be genuine and to relate to	the United States, the individual who	and if the presented it.
Name of Employer or Authoriz	ed Representative	Signature of Employer or Aut	horized Representative	Today's Date	(mm/dd/yyyy)
Additional Information (Initi	al and date each notation.)				rou used an cedure authorized mine documents.
Date of Rehire (if applicable)	New Name (if applicable)				
Date (mm/dd/yyyy)	Last Name (Family Name)		First Name (Given Name)		Middle Initial
	ree requires reverification, you prization. Enter the documen		present any acceptable List A opelow.	or List C documenta	tion to show
Document Title		Document Number (if any)		Expiration Date (if an	y) (mm/dd/yyyy)
			yee is authorized to work in to be genuine and to relate to		
Name of Employer or Authoriz	ed Representative	Signature of Employer or Aut	Today's Date	(mm/dd/yyyy)	
Additional Information (Initi	al and date each notation.)				ou used an cedure authorized mine documents.
Date of Rehire (if applicable)	New Name (if applicable)				
Date (mm/dd/yyyy)	Last Name (Family Name)		First Name (Given Name)		Middle Initial
	ree requires reverification, you orization. Enter the documen		present any acceptable List A opelow.	or List C documenta	tion to show
Document Title		Document Number (if any)		Expiration Date (if an	y) (mm/dd/yyyy)
			yee is authorized to work in to be genuine and to relate to		
Name of Employer or Authoriz	ed Representative	Signature of Employer or Aut	horized Representative	Today's Date	(mm/dd/yyyy)
Additional Information (Initi	al and date each notation.)	1			ou used an cedure authorized mine documents.

M.E.B.A. DATABASE UPDATE FORM

(Please fi<mark>ll out this form</mark> completely)

	mpietea: $_$		E	Email Address: _	
Name: _			RS' BENEFIC		
	(Last)		(First)		(M.I.)
(SSN	I – Last 4 D	igits) (Hor	ne Phone N	Number) (Cel	Il Phone Number)
	,	g Address)		(City, State)	(Zip)
_		t <u>Unlimited</u> Lic			
Steam	Motor	Gas Turbine	Deck	MMC Expiration	Date:
Chief	Chief	Chief	Master		
1 AE	1 AE	1 AE	C/M	STCW Endorseme	ent Expiration Date
2 AE	2 AE	2 AE	2 M		
3 AE	3 AE	3 AE	3 M	Mariner Referenc	e Number:
If highes	st License i	s Limited, spec	ify here:		
E D D E D	ngine/Deck leck leck ngine leck	Basic MS CBRD Of CMEO - (' - (3 year ex C Refreshe ficer – (5 ye	xpiration) er - (5 years)	
D	ngine Deck	Damage (ontrol & Ca Control/CB	risis Management RD - (5 years) tion - (5 years)	t – (Once)
	ngine Ieck Ieck	Damage (Drug Test	ontrol & Ca Control/CB ting/Collect	_	t – (Once)
D	eck .	Damage (Drug Test ECDIS - (control & Control/CB ting/Collection(Once)	RD - (5 years)	· · · · · · · · · · · · · · · · · · ·
D D	eck eck	Damage (Drug Test ECDIS - (EKMS - (ontrol & Control/CB ting/Collect (Once) 5 years)	RD - (5 years)	
D D E	leck leck leck	Damage (Drug Test ECDIS - (EKMS - (Enginero	ontrol & Control/CB ting/Collect (Once) 5 years)	RD - (5 years) tion - (5 years) ce Management -	
D D E E	leck leck leck ngine	Damage (Drug Test ECDIS - (EKMS - (Enginerod Helo Fire	control & Control/CB ting/Collect (Once) 5 years) com Resource	RD - (5 years) tion - (5 years) ce Management - 5 years)	
D D E E D E	leck leck leck ngine ngine/Deck leck ngine/Deck	Damage (Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar	control & Control/CB ting/Collect (Once) 5 years) om Resource fighting - (Snager - (Once)	RD - (5 years) tion - (5 years) ce Management - 5 years)	
D D E E D E E	Peck Peck Ingine Ingine/Deck Peck Ingine/Deck Ingine/Deck Ingine/Deck Ingine/Deck	Damage (Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi	control & Control/CB ting/Collect (Once) 5 years) om Resource fighting - (Snager - (Once) ip & Managip & Team	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once)	(Once)
D D E E D E E D	Peck Peck Peck Ingine Ingine/Deck Peck Ingine/Deck Ingine/Deck Ingine/Deck	Damage C Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E	control & Control/CB control/CB ting/Collect (Once) 5 years) om Resource fighting - (Son ip & Mana ip & Team ip & Team invironmen	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once)	(Once)
D D E E D E D E	Peck Peck Ingine Ingine/Deck Peck Ingine/Deck Ingine/Deck Ingine/Deck Ingine/Deck Ingine	Damage (Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E MEECE -	control & Control/CB ting/Collect (Once) 5 years) om Resource fighting - (Son ip & Mana ip & Team ip & Team invironmen	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once) tal Officer - (5 years)	(Once)
D D E E D E D E E	Peck Peck Ingine Ingine/Deck Peck Ingine/Deck Ingine/Deck Ingine/Deck Ingine	Damage C Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E MEECE - Small Ari	control & Control/CB ting/Collect (Once) 5 years) om Resource fighting - (Son ip & Manasip & Team nvironmen (Once) ns - (1 years	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once) tal Officer - (5 years)	(Once)
D D E E D E D E E D	Peck Peck Peck Ingine Ingine/Deck Peck Ingine/Deck Ingine/Deck Ingine/Deck Ingine	Damage C Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E MEECE - Small Art SST - (On	control & Control/CB control/CB conce) 5 years) om Resource fighting - (Son ip & Mana ip & Team ip & Team invironmen (Once) ins - (1 year ce)	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once) tal Officer - (5 years)	(Once)
D D E E D E D E D	eck leck leck leck legine legine/Deck leck legine/Deck leck leck legine leck leck legine	Damage C Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E MEECE - Small Arr SST - (On STCW Ba	control & Control/CB control/CB conce) 5 years) om Resource fighting - (Son ip & Mana ip & Team in vironmen (Once) ins - (1 year ce)	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once) tal Officer - (5 years) r) ng - (5 years)	(Once)
D D E E D E D E D E E	pleck	Damage C Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E MEECE - Small Arr SST - (On STCW Ba STCW Ta	control & Control/CB ting/Collect (Once) 5 years) om Resource fighting - (Son ip & Manasip & Team nvironmen (Once) ms - (1 year ce) asic Training	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once) tal Officer - (5 years) r) ng - (5 years) iliarization - (5 years)	(Once)
D D E E D E E D E E D E E E D E E E D E E E D E	eck leck leck leck legine legine/Deck leck legine/Deck leck leck legine leck leck legine	Damage C Drug Test ECDIS - (EKMS - (Enginerod Helo Firet LAN Mar Leadershi Marine E MEECE - Small Art SST - (On STCW Ba STCW Ta Tankship	control & Control/CB ting/Collect (Once) 5 years) om Resource fighting - (Son ip & Managip & Team in Wironmen (Once) ms - (1 year ce) asic Training mker Fami	RD - (5 years) tion - (5 years) ce Management - 5 years) ce) gement - (Once) work - (Once) tal Officer - (5 years) r) ng - (5 years) iliarization - (5 years)	(Once)

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 (<u>www.mebaplans.org</u>).
- 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 <u>only</u> 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 <u>must</u> 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	Ini	tial		
Social Security Number								
Date of Birth (mm/dd/yyyy)				Sex (Select one)	MaleFemale			
Home Telephone Number	(Area Code:)					
Cellular Phone Number	(Area Code:	(Area Code:						
E-mail address (If applicable)	@							
Affiliation (Check One)	O District No. 1-	O District No. 1-PCD, MEBA O Plan Employee O Union Employee O Other:						
Active/Pensioner (Check One)	O Active O 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)			O Married	O Widowed C	Divorced O Legally Sepa	rated		
Permanent Address (Home of Record):	Number & Street							
(Home of Record).	City, State, Zip							
Mailing Address	Number & Stree	t						
(if different than Permanent Address above):	City, State, Zip							
DEPEN	IDANTS TO BE A		ED TO YOU FULL NAM		L COVERAGE			
LAST NAME FIRST NAME INITI	DATE OF BIRTH		EPENDANT SS		RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT		
				o Ch	oouse nild	 Yes No		
If dependant is an adult child/adopte If eligible for Employment Based Co					Coverage? (check one) • Y	es ○ No		
Child's Employer Name	Child's Employe				's Employer Phone			
Child's Spouse's Employer Name	Child's Spouse's	Empl	loyer Address	Child	's Spouse's Employer Phone			

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN		TO	ATIONSHIP MEMBER HECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
					o Chi	ild	Adopted Child	o Yes
					o Ste	pchild	 Grandchild 	○ No
_		_		eligible for Employment	Based C	overag	e? (check one) OY	es o No
		sed Covera		e following sections				
Child's Employer	Name		Child's Employe	r Address	Child's	s Employ	er Phone	
Child's Spouse's Employer Name Child's Spouse's Employer Address C						s Spouse	's Employer Phone	
Clina's Spouse's Employer Natices						эрошье	s Emproyer i none	
								STEP/GRAND
LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN			ATIONSHIP MEMBER	CHILD CHECK IF
LAST NAME	TIKST NAME	IIIIAL	(MINI/DD/1111)	DEI ENDAMI SSM		_	HECK ONE	FT STUDENT
					o Chi	ld	Adopted Child	o Yes
					o Ste		 Grandchild 	o No
If dependant is	an adult child/a	adopted cl	nild, is he or she	eligible for Employment	Based C	overage	e? (check one) OY	es o No
_		_		e following sections		Ü		
Child's Employer	Name		Child's Employe	r Address	Child's	s Employ	er Phone	
Child's Spouse's I	Employer Name		Child's Spouse's	Employer Address	Child's	s Spouse	's Employer Phone	
					<u> </u>			
					1			STEP/GRAND
			DATE OF BIRTH			REL	ATIONSHIP	CHILD
LAST NAME	FIRST NAME	INITIAL	(MM/DD/YYYY)	DEPENDANT SSN			MEMBER	CHECK IF
					- (1)		HECK ONE	FT STUDENT
					∘ Chi		Adopted Child	o Yes
						1	o Grandchild	○ No
_		_		eligible for Employment	Based C	coverage	e? (check one) • Y	es O No
		sed Covera		e following sections	CI::1.12	- E1	Dl	
Child's Employer	Name		Child's Employer Address		Child's Employer Phone			
Child's Spouse's I	Employer Name		Child's Spouse's	Employer Address	Child's	s Spouse	's Employer Phone	
omia s spouse s i	projer rume		отпа в вроиве в	- Employer riddioss		. Броиве	2 Employer I none	
(Attac	h a separate sh	eet to you	r Permanent Da	nta Form if you have more	than fo	ur Dep	endants)	
Signature of					I			
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 Sex O Male Date of Birth (mm/dd/yyyy) (Select one) O Female Home Telephone Number (Area Code: Cellular Phone Number (Area Code: **(a**) E-mail address (If applicable) Affiliation (Check One) O District No. 1-PCD, MEBA O Plan Employee O Union Employee O Other: O Active O Pensioner If Actively Employed, Name of Present Employer: Active/Pensioner (Check One) Marital Status (Check One) ○ Married ○ Widowed ○ Divorced ○ Legally Separated Single

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* Last Name First Name Initial Relationship ☐ Co-Beneficiary Address of Beneficiary Number & Street City State Zip Beneficiary's Social Percent (%) % of Benefit: Security Number Sex o Male Date of Birth (mm/dd/yyyy) (Check One) o Female

CO-BENE	FICIARY (IES) OR (CONTINGENT I	BENEFI	CIARY (IES	
Name: Check One: ☐ Beneficiary or					
☐ Co-Beneficiary	Last Name	First Naı	me	Initial	Relationship
Address of Beneficiary					
	Number & Street	City	1	Sta	
Beneficiary's Social Security Number				Percent (%) of Benefit:	%
Date of Birth (mm/dd/yyyy)			Sex (Check One	MaleFemale	<u>.</u>
Name: Check One: ☐ Co-Beneficiary or				- Tomare	
☐ Contingent Beneficiary	Last Name	First Name		Initial	Relationship
Address of Beneficiary	N 1 0 0				
Danafiaiany's Casial	Number & Street	City	1	Percent (%)	1
Beneficiary's Social Security Number				of Benefit:	%
Date of Birth (mm/dd/yyyy)			Sex (Check One	MaleFemale	
				o remaie	
Name: Check One: ☐ Co-Beneficiary or					
☐ Contingent Beneficiary	Last Name	First Name		Initial	Relationship
Address of Beneficiary					
	Number & Street	City		Stat	
Beneficiary's Social Security Number				Percent (%) of Benefit:	%
Data of Dinth (111			Sex	o Male	
Date of Birth (mm/dd/yyyy)			(Check One	• Female	e
(Attach a separate sh	neet to your Permanent Data	Form if you have more	than two C	o-Beneficiaries)	
Signature of Employee	-	-	Dat		

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.