

# MEMBERSHIP APPLICATION & BENEFICIARY DESIGNATION

2153 Richmond Ave, Suite B-101, Staten Island, New York 10314  
(718) 370-0081 ♦ (800) 280-8610 ♦ Fax: (718) 370-0821 ♦ Email: Info@fct153.org

**PLEASE PRINT CLEARLY** Check one:  Mr.  Mrs.  Miss  Ms.

SOCIAL SECURITY NO.

NAME: \_\_\_\_\_

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ADDRESS \_\_\_\_\_

STREET NO.

CITY

STATE

ZIP

PHONE \_\_\_\_\_ CELL \_\_\_\_\_ PERSONAL EMAIL \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

NAME OF SCHOOL: La Salle Academy, 215 East 6<sup>th</sup> Street, New York, NY, 10003 DATE OF HIRE \_\_\_\_\_

CHECK ONE:  FULL TIME: \$51.00 per month  PART TIME: \$25.50 per month

Previous member of FCT/Local 153?  YES  NO If YES, give date of termination \_\_\_\_\_

Please list other schools at which you have been employed and time period for each school:  
\_\_\_\_\_  
\_\_\_\_\_

## BENEFICIARY INFORMATION (Please complete both sections)

<b>LOCAL 153 DEATH BENEFIT TO BE PAID TO:</b> (Use Full Name) <b>SOCIAL SECURITY #:</b>	<b>RELATIONSHIP (...husband, wife, father, mother, son, daughter, friend, etc.)</b>
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Beneficiary Address: \_\_\_\_\_  
STREET NO. CITY STATE ZIP

<b>OPEIU DEATH BENEFIT TO BE PAID TO:</b> (Use Full Name) <b>SOCIAL SECURITY #:</b>	<b>RELATIONSHIP (...husband, wife, father, mother, son, daughter, friend, etc.)</b>
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Beneficiary Address: \_\_\_\_\_  
STREET NO. CITY STATE ZIP

PLEASE SIGN AND DATE BELOW. **RETURN ENTIRE APPLICATION TO THE FCT OFFICE.**

## DUES DEDUCTION AUTHORIZATION

*I hereby request and authorize La Salle Academy, according to the arrangements agreed upon with the Union, to deduct from my salary and to transmit to the Union the dues/agency fee, as certified by the Union. I hereby waive the right and claim for said monies so deducted and transmitted in accordance with this authorization and release La Salle Academy of any liability thereof. This authority shall be irrevocable for a period of one year unless revoked by me in writing to La Salle Academy and to the Union during the thirty (30) day period designated by the Union in its By-Laws.*

DATE \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_