New York State Nurses Association
NYSNA Pension Plan
PO Box 12430
Albany, NY 12212-2430
PHONE (877) RN BENEFITS
FAX (518) 456-3954
www.rnbenefits.org

Pension Plan Enrollment Form

Social Security Number_____

First Name _____ Middle Initial _____ Last Name _____
(*Please use legal name only*)

Street Address _____ City _____ State _____ Zip + 4 _____-_____

Home Telephone (_____) _____ Sex ❑ Male ❑ Female Date of Birth _____/____/_____

E-mail Address _____

Employer _____ Employment Date _____/___/_____ RN Date _____/___/_____

Position Title _____ Work Status ❑ Full-time ❑ Part-time _____ Hours

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow/Widower

If Married: Spouse's Full Name _____ Date of Marriage ____/____/_____

Spouse's Date of Birth _____/_____/_____ Spouse's Social Security Number _____

If Divorced: Former Spouse's Full Name _____

Date of Marriage ____/____/_____ Date of Divorce ____/____/_____ Date of Birth _____/____/_____

If Widow/Widower: Spouse's Full Name _____

Date of Marriage ____/____/_____ Spouse's Date of Death ____/____/_____ Date of Birth ____/____/_____

Prior employment with employers covered by the NYSNA Pension Plan *(if applicable)*

Employer_____ Position Title_____ Employed from___/_____/____ to___/____/____

Employer_____ Position Title_____ Employed from___/_____/____ to___/____/____

Signature _____ **Date** _____

9/2010