2153 Richmond Ave, Suite B-101
Staten Island, NY 10314
(718) 370-0081 ● (800) 280-8610 ● Fax: (718) 370-0821 ● Email: info@fct153.org

MEMBERSHIP APPLICATION & BENEFICIARY DESIGNATION

Check one: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

NAME _____ _____ _____
LAST FIRST MIDDLE

ADDRESS _____ _____ _____ _____
STREET NO. CITY STATE ZIP

PHONE (____)_____ **CELL** (____)_____ **BIRTHDATE** ____/_____/_____

SOCIAL SECURITY# _____ **PERSONAL** E-MAIL _____

NAME OF SCHOOL_____ **YEARS IN THIS SCHOOL** _____

SCHOOL ADDRESS _____ _____ _____ _____
STREET NO. CITY STATE ZIP

PLEASE LIST OTHER SCHOOLS AT WHICH YOU HAVE BEEN EMPLOYED AND THE TIME PERIOD FOR EACH SCHOOL:

_____

_____

CHECK ONE: ☐ FULL TIME: Elementary and High School $51.00 per month
☐ PART TIME: Elementary and High School $25.50 per month

BENEFICIARY INFORMATION (Please complete both sections)

LOCAL 153 **DEATH BENEFIT TO BE PAID TO:** (Use Full Name) SOCIAL SECURITY #:	**RELATIONSHIP** (…husband, wife, father, mother, son, daughter, friend, etc.)

Beneficiary Address: _____ _____ _____ _____
STREET NO. **CITY** **STATE** **ZIP**

OPEIU **DEATH BENEFIT TO BE PAID TO:** (Use Full Name) SOCIAL SECURITY #:	**RELATIONSHIP** (…husband, wife, father, mother, son, daughter, friend, etc.)

Beneficiary Address: _____ _____ _____ _____
STREET NO. **CITY** **STATE** **ZIP**

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

DUES DEDUCTION AUTHORIZATION

I hereby designate the Federation of Catholic Teachers as my representative, for the purpose of collective bargaining, and I hereby request and authorize my employer, or any other member school of the Association which subsequently employs me during the period that this authorization form is in effect, and according to the arrangements agreed upon with the Union, to deduct from my salary and to transmit to the Union the dues, 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 my employer and any other member school of the Association that subsequently becomes my employer during the period this authorization is in effect of any liability thereof. This authority shall be irrevocable for a period of one year, and shall continue in full force and effect for successive periods of one year unless revoked by me in writing to the member school that is my employer at the time of said revocation and to the Union during the thirty (30) day period designated by the Union in its By-Laws, subject to the provisions of Article XXVI of the Collective Bargaining Agreement.

_____ _____
DATE EMPLOYEE'S SIGNATURE