DOYLE FIRE DISTRICT
MEMBERSHIP APPLICATION

Doyle No.1 _____ Application Date _____ Doyle No.2_____

CATEGORY:

INTERIOR FIRE FIGHTER _____ EMS RESPONDER _____

PERSONAL:

Name_____

Address_____

Town/City _____ State_____ Zip Code _____

Home Phone _____ Cell Phone_____ Social Security No. _____

Date of Birth _____ How long have you resided in the Doyle Fire District? _____

If less than seven years, please provide the complete address of each place you resided over the past seven years and the length of time you resided at each location_____

_____

_____

_____

Do you have a valid New York State Drivers License? YES _____ NO _____ (provide copy)

EMPLOYMENT:

Name of current employer _____

Employer address _____

Employer phone number _____Position held _____

Work hours _____

EDUCATION:

What is the highest grade level of education you have completed? _____

Name of Grammar School _____Name of High School_____

Name of College _____

MILITARY:

Have you ever been a member of the United States Armed Forces? YES _____ NO ____ Branch of Service_____

Did you receive an Honorable Discharge? Yes_____ NO _____ If no, explain_____

_____

FIREFIGHTING EXPERIENCE:

Do you have any previous firefighting or emergency service experience? YES _____ NO _____

If yes, name of agency _____

Address of agency _____

Contact person _____

Do you have any illness, disease, or disability which will in any way affect your ability to perform firefighting duties?
YES_____ NO_____

If yes, please explain _____

_____

PERSONAL BACKGROUND:

Have you ever been arrested for, or convicted of, a felony or misdemeanor? YES _____ NO_____

If yes, please provide the following: 1) Describe the exact charge or charges for which you have been arrested or convicted. 2) The dates of each arrest or conviction. 3) The location of each arrest or conviction including city/town, county, and state. 4) The name of the Court in which you were convicted. 5) Any explanation you may wish to provide.

_____

_____

_____

_____

Have you ever been charged with an offense involving insurance fraud or arson? YES_____ NO _____

If yes, explain_____

_____

_____

REFERENCES:

List three personal references:

	NAME	ADDRESS	PHONE NUMBER
1.			
2.			
3.			

I understand that I am required to sign the attached authorizations for release of information as part of this application and will sign any additional authorizations requested by the fire district in the future. I affirm that the statements made on this application are true under the penalties of perjury. I also understand I am required to take a physical exam for the membership category that I am applying for (interior fire fighter, EMS responder) and must be found medically fit before being accepted as a fire fighter. I am willing to undergo a medical examination by the district designated physicians.

APPLICANT'S SIGNATURE _____

DATE _____

CHEEKTOWAGA POLICE DEPARTMENT

3223 Union Road Cheektowaga, New York 14227

Brian J. Gould
Chief of Police

VOLUNTEER FIREFIGHTER BACKGROUND CHECK REQUEST FORM

Understand that this serves as a **local check** of records maintained by the **Cheektowaga Police Department** and **does not** search records a subject may have in other jurisdictions. **This record check does not replace a comprehensive background investigation.**

DATE: _____

NAME: _____

AKA (also known as): _____

MAIDEN NAME: _____

DATE OF BIRTH: _____ / _____ / _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____

EMAIL: _____

SIGNATURE: _____

FIRE DEPARTMENT: _____

*This notification shall entitle the person named or his authorized representative (representative must have notarized authorization from person named) to inspect the above-mentioned record and shall be in effect until 4:00pm on the day used. It may not be extended to another day without a new request for the inspection of records form.

DOYLE FIRE DISTRICT

NEW APPLICANT
ARSON BACKGROUND CHECK
INFORMATION SHEET

Name: _____
Last, First, Middle

Address: _____

Race:_____ Skin Tone:_____

Height:_____ Place of Birth:_____

Attach a copy of driver's license and Social Security Card

Renaissance

DENTAL • VISION • LIFE • DISABILITY

MEMBER ENROLLMENT FORM

—Please Type Or Print Clearly In Dark Ink—

SECTION I | INFORMATION

Name of Participating Organization: Doyle Fire District	Group ID Number: LINY40090
[Unit Name and Number:] 00204	Policy Number(s): LINY40090-00204
Date of Membership *(mm/dd/yyyy)*:	Billing Class:

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Re-enrollment ☐ Change in Status ☐ Other
If Other Specify: _____

SECTION II | MEMBER INFORMATION (Completed By Applicant)

Full Name *(Last, First, MI)*:	☐ Male ☐ Female	Email: Phone:	
Street Address *(Include Apt#/Suite)*:	City:	State:	ZIP Code:
Social Security Number:	Date of Birth *(mm/dd/yyyy)*:	Position Title:	

SECTION III | BENEFICIARY

Full Name (First, Last, MI)	Relationship To You	Address	Phone	Social Security Number	Percentage
CONTINGENT BENEFICIARY					

If you need more room, please request our Beneficiary form

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

SECTION IV | SIGNATURE

My signature on this Enrollment Form further represents that:

I am applying for the coverages designated for which I am eligible under my organization's plan with Renaissance and I understand that no coverages above the Guaranteed Issue Limit are effective until my completed Evidence of Insurability is approved by Renaissance. If I am applying as a Late Applicant, I understand that no coverage is effective until my completed Evidence of Insurability is approved by Renaissance and certain limitations may apply.

[I understand that if I am Hospital Confined, that coverage will be deferred until the day after Hospital Confinement ends.]

For any Life or AD&D coverage for which I am applying, I designate the Beneficiary(ies) named in the Beneficiary section of this Enrollment Form to receive any benefits payable in the event of my death.

ACCELERATED DEATH BENEFITS NOTICE: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. The portion of the death benefit which is accelerated will be discounted. There may be a processing fee upon acceleration.

[If this form is to be signed electronically, I agree that, by typing my name on the "Applicant's Signature"/"Spouse's Signature" line and entering my birth month and year below, I will be signing this Employee Enrollment Form and that such signature will be as legally binding as if I had manually signed this Employee Enrollment Form.]

The Enrollment Form is subject to approval, refusal or modification in accordance with Renaissance guidelines. Material misrepresentation will cause this form and subsequent coverage to be voidable (not applicable to Life Insurance).

[FRAUD WARNING (NOT APPLICABLE TO LIFE INSURANCE): ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.]

Member Signature *(Required)*	Member Date of Birth *(mm/dd/yyyy)*	Date Signed *(mm/dd/yyyy)*

Arch
Insurance Group®

Arch Insurance Company

Beneficiary Designation Form

Use this form to designate a beneficiary(ies) for your Accidental Loss of Life Benefit Amount. See page 2 for important information on choosing beneficiary(ies). Complete a new form if you want to designate a new or additional beneficiary(ies).

Policyholder Name and Address

Name Doyle FIRE DIST. #1

Address 2199 William ST. CHEEKTOWAGA N.Y. 14206

Insured Information

Insured Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Daytime Telephone Number _____

Beneficiary Information

I am: (Please check appropriate box.)

☐ Designating a beneficiary(ies) for the first time ☐ Changing a previous designation

Primary Beneficiary(ies) Full Name (Last, First, MI)	Address	Birth Date	Social Security	Relationship to	Share %

Contingent Beneficiary(ies) Full Name (Last, First, MI)	Address	Birth Date	Social Security	Relationship to	Share %

Authorization

For the beneficiary designation(s) I have indicated, I understand that if one of my primary beneficiaries is not living when the benefit is paid, the amount will be divided equally among any remaining beneficiaries. I also understand that no amount will be paid to a contingent beneficiary as long as at least one of my primary beneficiaries is living. I understand that I must complete a new Beneficiary Designation Form if I want to change or revoke my beneficiary designation.

Insured Signature _____ Date _____

Please make a copy of this form for your records and return the original.

(over)

Authorization

Designate a primary and contingent beneficiary for insurance coverage. Refer to the sample wording below for guidance. A contingent beneficiary receives payment in the event the primary beneficiary dies before you do. If you want more than one person to be your beneficiary, please indicate the percentage of the benefit each one should receive (must add up to 100%). If a beneficiary dies before you, his or her benefits will be shared equally among any remaining beneficiaries. Attach a separate signed and dated sheet of paper if you need more space. If you have a change in your family status (such as marriage; divorce; or the birth of a child), you may want to update your beneficiary designations.

Sample Beneficiary Designations

Type of Beneficiary	**Sample Wording**
One beneficiary.....	Doe, John A.; Birthdate; SSN; Husband; 100%
Two beneficiaries.....	Doe, Mary A.; Birthdate; SSN; Mother; 50% Doe, Rich B.; Birthdate; SSN; Father; 50%
Two beneficiaries in unequal shares.....	Doe, Amy J.; Birthdate; SSN; Mother; 75% Doe, Mark F.; Birthdate; SSN; Father; 25%
Three or more beneficiaries in unequal shares.....	Doe, Paul A.; Birthdate; SSN; Father; 75% Doe, James B.; Birthdate; SSN; Brother; 25% Doe, Jaclyn C.; Birthdate; SSN; Sister; 25%
Mark Doe, trustee under trust agreement; Jane Doe Revocable Trust; xxx Main Street; Any Town, State 00000; Dated Month day, year; and amendments or supplements thereto. Any payment to the trustee shall discharge the Plan from any and all liability to the extent of such payment.	

If your beneficiary designations do not fit within the tables on the front of this form, feel free to write the appropriate designation(s) on a separate sheet of paper. Sign and date the separate sheet and attach it to this form.

- All beneficiary designations **must be legible and written in ink.**
- The beneficiary's name must always be shown in full (Last; First; MI), and the relationship to you must be stated.
- If the designated beneficiary is not related to you, the relationship should be "friend."
- The beneficiary section should never contain corrections or crossed-out words.
- The beneficiary designation should be specific. It should not include wording such as "either/or" ; and/or."
- Your right to designate a beneficiary is subject to applicable state law.

Note: For specific legal implications regarding beneficiary designations, contact your attorney.

DOYLE FIRE DISTRICT NO. 1
SERVICE AWARD PROGRAM

BENEFICIARY DESIGNATION FORM

By completing this form, you designate who is to receive any death benefit that may be payable under the provisions of the above named service award program. Completing this form does not guarantee that a benefit will be paid upon your death. It is important that you provide all the requested information in the event that we have to attempt to locate your beneficiary. If all of your beneficiaries listed below are deceased, the death benefit will be paid to your estate.

Please consult with an attorney before naming a minor child or your estate as a beneficiary; typically death benefits can not be paid directly to a minor. To name more than 3 primary or contingent beneficiaries, please complete two forms and indicate "page 1 of 2" on the first form and "page 2 of 2" on the second form.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK

********** PARTICIPANT DATA - PLEASE FILL OUT COMPLETELY **********

_____ ___-___-____ ___/___/____

Volunteer First Name, MI, Last Name | Social Security Number | Date of Birth

_____ _____

Volunteer Mailing Address | City | State | Zip | Fire Company

********** PRIMARY BENEFICIARIES **********

Please list the person or persons you wish to receive the death benefit. If you list more than one person, each person listed will equally share the death benefit, provided they are alive as of your date of death. If one or more of your primary beneficiaries are deceased, the remaining primary beneficiaries will equally split the death benefit. If all of your primary beneficiaries are deceased, the benefit will then be paid to those you list under "CONTINGENT BENEFICIARIES".

	First, MI, Last Name	Relation	Date of Birth	Soc. Sec. No.	Mailing Address	City	State	Zip
1.								
2.								
3.								

********** CONTINGENT BENEFICIARIES **********

If all of your primary beneficiaries are deceased, the benefit will then be paid to those you list here. If one or more of your contingent beneficiaries are deceased, the remaining contingent beneficiaries will equally split the the death benefit.

	First, MI, Last Name	Relation	Date of Birth	Soc. Sec. No.	Mailing Address	City	State	Zip
1.								
2.								
3.								

********** SIGNATURE AND WITNESS **********

I hereby designate those named above as my beneficiaries and declare that this designation supercedes all previous beneficiary designations.

_____, _____ _____, _____

Volunteer Signature and Date | Witness Signature and Date

Witness must be a Notary, or an Official of the Fire District or Fire Department

Form Updated 11/5/2010