DOYLE FIRE DISTRICT
MEMBERSHIP APPLICATION

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

CATEGORY:

Interior Firefighter ☐ EMS Responder ☐ Junior Firefighter ☐

PERSONAL:

Name: _____

Address: _____

Town/City: _____State: _____ Zip Code: _____

Home Phone: _____Cell Phone: _____ SSN: _____

Date of Birth: _____

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

If less than seven years, please provide 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 Driver's 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?

If yes, name of agency: _____

Address of Agency: _____

Contact Person: _____

Do you have an illness, disease, or disability which will in anyway affect your ability to perform firefighting duties? YES ☐ NO ☐ If Yes, please explain: _____

_____

PERSONAL BACKGROUND:

Have you ever been arrested, 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 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 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

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.

Renaissance®

DENTAL · VISION · LIFE · DISABILITY

Renaissance Life & Health
Insurance Company of New York
[2 Court St. Binghamton, NY 13901]
NEW YORK

MEMBER ENROLLMENT FORM

—Please Type Or Print Clearly In Dark Ink—

SECTION I | INFORMATION

Name of Participating Organization: Doyle Fire District #1	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

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)*

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DENTAL · VISION · LIFE · DISABILITY

GROUP INSURANCE BENEFICIARY FORM

—Please Type Or Print Clearly In Black or Blue Ink—

INSTRUCTIONS:

COMPLETE THIS FORM IF: (1) More than one beneficiary is to be named under the certificate of insurance; or (2) The present beneficiary designation(s) for proceeds payable on the death of the certificate holder under the certificate of insurance is intended to be replaced by the new designation(s).

- A separate group insurance beneficiary form must be used for each certificate of insurance.
- Cross outs **are not** acceptable.
- **SURVIVING BENEFICIARY(IES):** Unless otherwise provided, all surviving beneficiaries in each class shall share equally and no beneficiary in a subsequent class shall receive payment unless all beneficiaries in the preceding class have predeceased the certificate holder.
- By providing all of the requested information, Renaissance* will be better able to promptly process the payment of a death benefit in the event of the certificate holders death and minimize requests for additional information.
- **SPLIT BENEFICIARY(IES):** If you wish the proceeds to be split among beneficiaries, use percentages totaling 100%. Do not use dollar amounts.
- **CHILDREN OF THE CERTIFICATE HOLDER:** Insurance regulation requires that we request specific identifying information for all children specified as beneficiaries. Therefore, "children of the certificate holder" is not an acceptable designation. Please name each living child and include his or her gender, date of birth, phone number, social security number, address and relationship to the certificate holder. Be sure to complete a new group insurance beneficiary form to add additional children born or legally adopted.
- The maximum period for deferred survival is 90 days.
- Spouse of certificate holder residing in the following community property states must sign the Group Insurance Beneficiary Form: AZ, CA, ID, LA, NV, NM, TX, WA, WI.
- If group insurance is through employment, the employer may not be named beneficiary.
- It is important that you review your beneficiary designation periodically to ensure that the beneficiary information supplied is current.
- You may change or revoke your beneficiary designation at any time by completing a new Group Insurance Beneficiary Form.

**The term Renaissance shall include both Renaissance Life & Health Insurance Company Of America and Renaissance Life & Health Insurance Company Of New York.*

SECTION I | CERTIFICATE HOLDER INFORMATION

Certificate Holder Full Name *(Last, First, MI)*:	Social Security Number:
	Phone Number:

Street Address *(Include Apt#/Suite)*:	City:	State:	ZIP Code:

Employer/Group Name:	Group Policy Number:	Email:
Doyle Fire District #1	LINY40090-00204	

SECTION II | PRIMARY BENEFICIARY(IES)

	Beneficiary(ies) Name *(Last, First, MI)*	Male *(M)* Female *(F)*	Relationship	Date of Birth *(mm/dd/yyyy)*	Social Security Number	% of Benefit
1.		☐M ☐F				
2.		☐M ☐F				
3.		☐M ☐F				

BENEFIT PERCENTAGE MUST TOTAL: 100%*

	Beneficiary(ies) Address *(Include Apt#/Suite)*	Phone Number	City	State	ZIP Code
1.					
2.					
3.					

SECTION III | CONTINGENT BENEFICIARY(IES)

*I wish the following to receive proceeds **ONLY** if the primary beneficiary(ies) stated above all die before the certificate holder.*

	Contingent Beneficiary(ies) Name *(Last, First, MI)*	Male *(M)* Female *(F)*	Relationship	Date of Birth *(mm/dd/yyyy)*	Social Security Number	% of Benefit
1.		☐M ☐F				
2.		☐M ☐F				
3.		☐M ☐F				

BENEFIT PERCENTAGE MUST TOTAL: 100%*

	Contingent Beneficiary(ies) Address *(Include Apt#/Suite)*	Phone Number	City	State	ZIP Code
1.					
2.					
3.					

SECTION IV | CONTINGENT BENEFICIARY(IES)

*I wish the following to receive proceeds **ONLY** if the primary beneficiary(ies) stated above all die before the certificate holder.*

	Contingent Beneficiary(ies) Name *(Last, First, MI)*	Male *(M)* Female *(F)*	Relationship	Date of Birth *(mm/dd/yyyy)*	Social Security Number	% of Benefit
1.		☐M ☐F				
2.		☐M ☐F				
3.		☐M ☐F				

BENEFIT PERCENTAGE MUST TOTAL: 100%*

	Contingent Beneficiary(ies) Address *(Include Apt#/Suite)*	Phone Number	City	State	ZIP Code
1.					
2.					
3.					

***Add Future Children as Split Beneficiaries:** ☐Yes ☐No *(Please refer to the definition of child in your certificate of insurance.)*
If you elect to "Add Future Children as Split Beneficiaries", all current and future children will be added as beneficiaries with the percentage of benefit equally split among all child beneficiaries.

TRUST AS BENEFICIARY: *(Complete this section only if you are naming a trust as beneficiary and the trust document will govern the disposition of the death benefit proceeds. A valid trust document must be in existence prior to naming the trust as Beneficiary.)*

Must Check One: ☐ Primary ☐ Contingent **Must Check One:** ☐ Revocable Trust ☐ Irrevocable Trust

Trust Name _____ **Trust Date** *(mm/dd/yyyy)* _____ **Trust Tax ID Number** _____

Trustee Name(s) _____ **Street Address** *(Street, City, State, ZIP)* _____ **Percentage** _____

Unless otherwise provided, all beneficiaries in a class who survive the Certificate holder shall share the death benefit equally, and no beneficiary in a subsequent class shall receive payment unless all beneficiaries in the preceding class have predeceased the certificate holder.

SECTION V | SUGGESTED PHRASEOLOGY FOR DESIGNATION OF BENEFICIARIES

Type	Language
1. Certificate holder's estate	Executors or Administrators of Certificate holder's Estate
2. One beneficiary of a class	Mary Doe, wife *(not Mrs. John Doe)*
3. Two or more beneficiaries of a class	Jane Doe, daughter, and James Doe, son
4. Unequal portions	Jane Doe, daughter, three-fourths *(75%)* and James Doe, son, one-fourth *(25%)*
5. Deceased primary beneficiary's share to go to secondary beneficiary and not to be divided between surviving primary beneficiaries	Jane Doe, daughter, and James Doe, son, however, if Jane Doe shall go to her children.
6. Creditor	ABC Bank, as its interest may appear; balance, if any, to _____.
7. Trustee	ABC Bank, as trustee under trust agreement dated _____.
8. Testamentary Trustee	The qualified testamentary trustee(s), under the Certificate holder's Last Will and Testament

SECTION VI | CONDITIONS OF DESIGNATIONS

1. THIS DESIGNATION IS SUBJECT TO ANY COLLATERAL ASSIGNMENT OF THE CERTIFICATE ACCEPTED BY AND FILED WITH RENAISSANCE, WHETHER MADE PRIOR OR SUBSEQUENT TO THE DATE OF THIS DESIGNATION.
2. RENAISSANCE ASSUMES NO RESPONSIBILITY FOR THE PROPER USE OF MONEY BY ANY TRUSTEE, CUSTODIAN, GUARDIAN, EXECUTOR OR OTHER BENEFICIARY NAMED HEREIN AND IS RELEASED FROM ALL LIABILITY RELATED TO MAKING PAYMENT IN ACCORDANCE WITH THIS DESIGNATION.
3. UNLESS OTHERWISE EXPRESSLY PROVIDED HEREIN, THE CERTIFICATE HOLDER RESERVES THE RIGHT, WITHOUT CONSENT OF ANY BENEFICIARY, TO REVOKE THIS DESIGNATION AND TO CHANGE THE BENEFICIARY AT ANY TIME BY NOTIFYING THE RENAISSANCE IN WRITING AT ITS HOME OFFICE. SUCH CHANGE SHALL BE WITHOUT PREJUDICE TO RENAISSANCE ON ACCOUNT OF ANY PAYMENT MADE OR ACTION TAKEN BY IT BEFORE FILING SUCH CHANGE IN ITS HOME OFFICE.
4. RENAISSANCE HAS THE RIGHT TO REFUSE TO FILE ANY DESIGNATION WHICH DOES NOT COMPLY WITH ITS RULES AND REGULATIONS.
5. ONCE RECEIVED BY RENAISSANCE, THE DESIGNATION WILL TAKE EFFECT AS OF THE DATE THE CERTIFICATE HOLDER SIGNED THE DESIGNATION. UNTIL THE DESIGNATION IS RECEIVED, RENAISSANCE WILL NOT BE LIABLE FOR ANY ACTION TAKEN IN GOOD FAITH CONTRARY TO DIRECTIONS CONTAINED IN THE DESIGNATION.
6. ALL DESIGNATIONS ARE SUBJECT TO THE TERMS AND CONDITIONS OF THE GROUP POLICY.

SECTION VII | DESIGNATIONS

THIS DESIGNATION IS SUBJECT TO THE FOLLOWING SELECTED ☑ PARAGRAPH:

☐ **DEFERRED SURVIVAL**—If any beneficiary designated shall survive the Certificate holder but shall die before the _____ day *(not to exceed 90 days)* after the death of the Certificate holder *(exclusive of the date of death)*, proceeds shall be paid in the same manner as if the beneficiary had predeceased the Certificate holder.

☐ ***PAYMENT OF A MINOR CHILD'S SHARE TO TRUSTEE**—Any payment which becomes due a child under the age of twenty-one (21) shall be made to_____, (s)he currently resides at_____ as Trustee under a Trust Agreement dated _____.

* *This option cannot be selected unless a legal Trust Agreement has been entered into by you and the elected Trustee in advance of the Trustee being named in this form. Renaissance will not accept this designation unless the date of the Trust Agreement appears on this form.*

X _____ _____
Signature **Date Signed** *(mm/dd/yyyy)*

X _____ _____
Witness *(Recommended in All States)* **Date Signed** *(mm/dd/yyyy)*

_____ _____
Certificate Holder **Spouse, if resident of a community property state** *(See Page 1)*

Do you know that if death occurs and you have named a minor child (a person under age twenty-one (21)) or your estate as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid? This could mean legal expenses for the beneficiary and possible delay in the payment of the insurance. Please take this into consideration when naming your beneficiary. You may wish to consult an attorney regarding a designation under your state's Uniform Transfers to Minors Act, if available.

FOR RENAISSANCE USE ONLY:

Original filed with the Renaissance on *(mm/dd/yyyy)*: _____

Printed Name: _____ **Signature:** _____

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 NY. 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)