

**CURRY COUNTY FIRE
VOLUNTEER FIRE DISTRICT MEMBERSHIP APPLICATION**

Application for: _____ Fire District
Name: _____ Phone: _____
Home Address: _____
Employer: _____ Occupation: _____
Employer Address: _____

Firefighting involves a stressful work environment where an individual is subject to extremes in temperatures and life threatening situations. The following abilities are **EXPECTED** of members of the volunteer fire department; please indicate if you are able to perform the duties listed:

- Lift equipment weighing fifty- (50) pounds, and carry for a distance of one hundred (100) feet. _____
- Walk, kneel, stand, and crawl while wearing bunker gear and SCBA. _____
- Perform tasks in extreme temperatures, while wearing protective equipment. _____
- Listen to, understand, and carry out orders in emergency situations. _____
- Function within a wide range of unregulated environmental conditions. _____
- You are not required to disclose information about your physical or mental limitations that you believe will not interfere with capability to perform the duties of a firefighter, yet if you wish for the department to consider special arrangements to accommodate a physical or mental impairment, please identify that impairment and furnish suggestions for appropriate accommodations in the space provided.

List any previous firefighting or related experience: _____

List the name and phone numbers of three References:

Are currently a member of any other fire department? _____
Are you a resident of or employed with in the fire district to which you are applying for membership? _____
Are you willing to respond to fires, attend department meetings, trainings, and drills? _____

I, _____, do hear by swear that the above listing information is true and correct.

Signature: _____ Date: _____



PERA

Public Employees
Retirement Association
of New Mexico

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(505) 476-9300 voice
(800) 342-3422 Toll-Free
www.nmpera.org

MEMBER ENROLLMENT FOR VOLUNTEER FIREFIGHTERS FORM

Instructions: The original of this form must be completed in its entirety and returned to PERA for processing.

Required fields are in ***BOLD ITALICS***. Please print clearly.

MEMBER INFORMATION					
<i>SOCIAL SECURITY NUMBER</i>					
<i>FIRST NAME</i>			<i>MI</i>	<i>LAST NAME</i>	
<i>Previous First Name</i>			<i>Previous Last Name</i>		
<i>MAILING ADDRESS</i>				<i>HOME or CELL TELEPHONE NO.</i>	
				<i>BUSINESS TELEPHONE NO.</i>	
<i>CITY</i>	<i>STATE</i>	<i>ZIP</i>	<i>GENDER</i> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
<i>DATE OF BIRTH</i>	CITY OF BIRTH		STATE OF BIRTH		
<i>HAVE YOU EVER BEEN A PERA MEMBER?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO			<i>EMAIL ADDRESS</i>		
<i>EMAIL ADDRESS</i>					
MARITAL INFORMATION					
<i>CURRENT MARITAL STATUS (Check One)</i> <input type="checkbox"/> NEVER BEEN MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED					
SPOUSE'S NAME		SSN		DATE OF BIRTH (mm/dd/ccyy)	
<i>MEMBER CERTIFICATION</i>					
I hereby declare that all the above information is true and complete to the best of my knowledge.					
<i>SIGNATURE OF VOLUNTEER FIREFIGHTER</i>				<i>DATE</i>	
<i>VOLUNTEER FIREFIGHTER DEPARTMENT CERTIFICATION MUST BE COMPLETED BY THE FIRE CHIEF</i>					
Please copy the completed application for the department's file and for the Volunteer Firefighter. Return the original form to PERA immediately upon completion with a copy of the Volunteer Firefighter's social security card and driver's license.					
<i>NAME OF VOLUNTEER FIREFIGHTER DEPARTMENT</i>					
<i>PERA VFD NUMBER</i> 09 _____			<i>START DATE</i> (mm/dd/ccyy)		
I certify that the above-named individual is a Volunteer Firefighter of this department as of the above date.					
<i>SIGNATURE OF FIRE CHIEF or DESIGNEE</i>			<i>DATE OF SIGNATURE</i> (mm/dd/ccyy)		
<i>EMAIL ADDRESS</i>			<i>BUSINESS or CELL TELEPHONE NO.</i>		

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Please include a copy of your Driver's License and Social Security Card. Thank you!



Beneficiary Designation for Accident & Sickness Policy

Complete this section each time this form is used—Please Print

Name of Organization _____ State _____

Member's/Employee's Name _____

Member's Date of Birth _____ Date Member Joined Organization _____

Complete, sign and date this section if you wish to name or change your beneficiary.

I hereby designate the following beneficiary(ies) with respect to amounts payable as indemnity for loss of life under the referenced Accident & Sickness Policy and hereby revoke any designation of beneficiary thereunder heretofore made by me. I direct that any amounts payable under said policy to my beneficiary(ies) named below be paid to those of Primary Beneficiary who survive me, otherwise to those surviving in Contingent Beneficiary, in proportion to the percentages listed.

Primary (Please see below for examples)

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

Contingent

Beneficiary: Name _____ Relationship _____ Date of Birth _____ Share _____ %

Name _____ Relationship _____ Date of Birth _____ Share _____ %

If none of the above-named beneficiaries are living at the time of my death, I direct that payment be made in accordance with the terms of the policy. I reserve the right to revoke or change this designation.

Signature _____ **Date** _____

This form should be retained in the files of your department or organization and reviewed and updated on a regular basis.

Specifying Beneficiaries

Individual (always show relationship to the insured)	*Primary Beneficiary	**Contingent Beneficiary	Second Contingent Beneficiary
One Beneficiary	Jane Ann Jones, wife, 100%	(leave blank)	(leave blank)
One Primary Beneficiary and one Contingent Beneficiary	Jane Ann Jones, wife, 100%	David Lee Jones, son, 100%	(leave blank)
Two primary beneficiaries and one contingent beneficiary	Arthur Leo Jones, father, 50% Grace Hays Jones, mother 50%	Marie Jones Ford, sister, 100%	(leave blank)
One Primary Beneficiary, unnamed children as first Contingent Beneficiary and two second Contingent Beneficiaries	Jane Ann Jones, wife, 100%	Children born of my marriage to Jane Ann Jones, to share equally	Arthur Leo Jones, father, 50% Grace Hays Jones, mother, 50%
Unequal distribution (always use percentages)	Grace Hays Jones, mother, 50% Mary Jones Ford, sister, 25% William Roger Jones, brother, 25%	Surviving Primary Beneficiaries share equally in the portion designated for any Beneficiary(ies) who predeceases the insured	(leave blank)
Insured's Estate	Executors, Administrators or Assigns of the Insured	(leave blank)	(leave blank)

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.