



# FAIRFAX COUNTY POLICE ASSOCIATION

## Membership Application

www.thefcpa.org

Member Name (print): Last	First	M.I.	Social Security Number:	Date of Birth (mo/day/yr):	<input type="checkbox"/> Male
					<input type="checkbox"/> Female
Home Address: Street	City	State	Zip	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
E-mail Address:				Home Phone Number (include area code):	
Member Status: <input type="checkbox"/> New <input type="checkbox"/> Re-instatement				FCPD Status: <input type="checkbox"/> Sworn <input type="checkbox"/> Non-Sworn	
Current Rank:				Current Station Assignment or Work Location:	

Life insurance benefits for which this Association becomes liable by the acceptance of this application and continued good standing of the member as provided for in the By-laws will be paid to the named beneficiary or the alternate beneficiary, whichever survives the applicant. Should the applicant survive both, his or her spouse becomes the beneficiary unless the applicant names another by written request.

I wish to become a member of the Fairfax County Police Association and agree to pay the required monthly dues. I authorize the Fairfax County Government to deduct from my earnings such amounts of dues as may now or hereafter be payable by me to the **Fairfax County Police Association**.

I hereby pledge to abide by the By-laws of the Association and fulfill all obligations inherent with my membership.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION</b>	
Name: _____	Effective date: <u>ASAP</u>
SSN: _____	Deduction: <u>\$16.00/pay period</u>
County Agency: <b>Fairfax County Police Dept.</b>	Organization: <b>Fairfax County Police Association</b>
<p>I hereby authorize my employer, the Fairfax County Government to deduct from my earnings such amounts of dues as may now or hereafter be payable by me to the <b>Fairfax County Police Association</b>. This agreement shall remain in effect until such time as it is amended or rescinded by me in writing.</p>	
<p>Signature: _____ Date: _____</p>	

**IMPORTANT**

**New members and re-instated members must complete the payroll deduction authorization section.**

**Return all completed forms to:**  
**Fairfax County Police Association Business Office**  
**5625 Revercomb Ct.**  
**Fairfax, Virginia 22030**

Please call (703) 278-8626 if you have any questions

**Fairfax County Police Association, Inc.  
Enrollment and Change Form**

**Mark all boxes and complete all sections that apply. Return completed form to Fairfax County Police Association, Inc.**

<b>APPLICANT</b>	Your Name (Last, First, Middle)		Group Name <b>Fairfax County Police Association, Inc.</b>		Group Number(s) <b>144908</b>
	Your Address		City	State	ZIP
	Your Soc. Sec. No.	Date of Birth	Gender	Duty Assignment	Auxiliary <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>LIFE</b>	<i>Check with Fairfax County Police Association, Inc. about coverage options available to you and Evidence Of Insurability requirements.</i> <b>Life Insurance</b> <input checked="" type="checkbox"/> Life Insurance <b>Additional/Optional Life</b> <i>You must be an active non-auxiliary employee to be eligible to elect this coverage.</i> <input type="checkbox"/> Additional/Optional Life      Your requested amount \$ _____				
	<i>This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i>				
<b>BENEFICIARY</b>	Primary - Full Name		Address	Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address	Soc. Sec. No.	Relationship % of Benefit
<b>CHANGE</b>	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____      Former name _____ <input type="checkbox"/> Other _____				
	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.				
<b>SIGNATURE</b>	Member/Employee Signature Required			Date (Mo/Day/Yr)	
<b>Fairfax County Police Association, Inc. - Complete this section. Retain form for your records.</b>					
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.