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):	□ Male □ Female
Home Address: Street City State Zip		Marital Status: □ Single □ Married □ Widowed □ Divorced	
E-mail Address:		Phone Number (include area code):	
Member Status: ☐ New ☐ Re-instatement ☐ Spouse		FCPD Status: ☐ Sworn ☐ Non-Sworn	
Current Rank:		Current Station Assignment or Unit & 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 contingent 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:** ______________________

EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION

Name: ______________________________	Effective date: ASAP
SSN: ______________________________	Deduction: $18.25/pay period
County Agency: **Fairfax County Police Dept.**	Organization: **Fairfax County Police Association**

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 **Fairfax County Police Association**. This agreement shall remain in effect until such time as it is amended or rescinded by me in writing.

Signature: ______________________________ Date: ____________________

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

BENEFICIARY DESIGNATION

☑ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer: Fairfax County Police Association		Policy Number: 0GL891299

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: ______ Date of Birth: ______
Address: ______ Telephone Number: ( )
Social Security Number: ______ Relationship: ______ Benefit Percent: ______ %

Name: ______ Date of Birth: ______
Address: ______ Telephone Number: ( )
Social Security Number: ______ Relationship: ______ Benefit Percent: ______ %

Name: ______ Date of Birth: ______
Address: ______ Telephone Number: ( )
Social Security Number: ______ Relationship: ______ Benefit Percent: ______ %

CONTINGENT BENEFICIARY(IES)

Name: ______ Date of Birth: ______
Address: ______ Telephone Number: ( )
Social Security Number: ______ Relationship: ______ Benefit Percent: ______ %

Name: ______ Date of Birth: ______
Address: ______ Telephone Number: ( )
Social Security Number: ______ Relationship: ______ Benefit Percent: ______ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: ______ **Date:** ______

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: ______ **Date:** ______

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)