LESSLIE FIRE DEPARTMENT

Membership Application Package

Please Print Clearly

Page 1 – Membership Application Form &
Occumed – Drug Screening Form – (conducted after voting in)

Page 2 – Criminal Record Background Check Request Form
Required by South Carolina State Fire Marshal

Page 3 – South Carolina Firefighter Registration Form

Page 4 – Individual Member Application Form
South Carolina State Firefighter Association

Pages 1 – 4 Must be completed and returned before 1st reading can be held

Pages 5 thru 12 – County & State Beneficiary Forms
South Carolina State Firefighter Association

Pages 5 thru 12 Must be completed and returned before a vote can be held

Page 12 – VFIS Beneficiary Form
VFIS Benefit Summary – **To be kept by Applicant for record**

LFD
2014

LESSLIE FIRE DEPARTMENT
APPLICATION FOR MEMBERSHIP

Please complete all information
Please print clearly

Full name: _____ Date:_____

SSN: _____ Date of Birth:_____

Current Address: _____

City: _____ State: _____ Zip:_____

Phone #: _____ Cell: _____ Email: _____

Employment: _____

Position: _____ Time Employed:_____

Emergency Notification Contact: _____

Phone #: _____ Relationship: _____

Time Available for response:_____

Are you available to assist in other projects during the year? : _____

Please give a brief statement as to why you wish to join this Organization:_____

Please attach a copy of your current drivers record. Not the on line report. By signature you agree to a required Criminal Background check.

The above statements are, to the best of my knowledge, true and correct. I have read and understand the rules and regulations of this Department and will, to the best of my abilities, uphold them. I am aware of the drug policy and will comply when required.

Signature: _____ Date: _____

For Official use only

Date Applied: _____ Date Accepted: _____
Date of Termination: _____ Reason for Term:_____

Patient Treatment Authorization

Arrowood Medical Center • Occumed at Riverview • Riverview Medical Center

Patient Name _____ Date _____ Time _____ AM PM

Company Lesslie Fire Department Location *(if multiple sites)* _____

Does employee work for a temp agency? ☐ Yes ☐ No If yes, who? _____

Treatment authorized by: Name and Title *(please print)* Douglas R Morris - Deputy Chief

Signature Douglas R Morris Phone (803) 493-6752

Please treat the above patient for the following services... *(Please check all that apply.)*

☐ **Injury/Accident** Date of Injury _____ Date Employee Last Worked _____

Injured Body Part _____

Drug and/or Alcohol Testing *(Please check type and reason below)*

Type of Test

Using our lab and MRO

☐ Breath Alcohol Test (*Please check* ☐ DOT *or* ☐ Non-DOT)
☒ 5-Panel Urine Drug Screen (Non-DOT)
☐ DOT Urine Drug Screen (Expanded 5-Panel)
Please check one... ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG
☐ **Rapid** Urine Drug Screen (Non-DOT)
(*Please check* ☐ 5-panel *or* ☐ 10-panel)
(2-hour turn-around for negative results)
☐ 9-Panel Urine Drug Screen (Non-DOT)
☐ 10-Panel Urine Drug Screen (Non-DOT)
☐ **Hair** 5-Panel Drug Screen

OR

Using your company paperwork, lab and MRO

☐ **Collection Only** Urine Drug Screen ☐ DOT ☐ Non-DOT
☐ **Collection Only** Hair Drug Screen
☐ **Using Your Rapid Kit** Rapid Urine Drug Screen ☐ 5-panel ☐ 9-panel ☐ 10-panel ☐ Other _____

Reason for Drug/Alcohol Testing

☒ Pre-Placement ☐ Post-Injury ☐ Reasonable Suspicion
☐ Random ☐ Return-to-Duty ☐ Job Specific
☐ Post-Accident ☐ Follow-Up ☐ Other _____

Photo ID is required!!

Physical Examination

☐ DOT (*Please check* ☐ New Certification *or* ☐ Re-Cert *or* ☐ Follow-Up)
☐ Pre-Placement Basic (Non-DOT)
☐ Annual
☐ Respirator Clearance ☐ with Fit Test ☐ without Fit Test
☐ Return-to-Work Evaluation
(Notes and release from patient's treating physician are required.)
☐ Special Company Protocol _____
☐ Other _____

Other Services:

☐ Physical Abilities Test (PAT)
☐ TB Skin Test/PPD
☐ Hepatitis A Vaccine
☐ Hepatitis B Vaccine
☐ Audiogram
☐ Flu Vaccine
☐ Blood Lead Level
☐ Titmus Vision
☐ Ishihara 14-plate Color Vision
☐ Other _____

Company Contact for results and/or physician call Douglas R Morris - Deputy Chief

Preferred communication *(please check all that apply)* ☐ phone ☐ fax ☐ e-mail ☒ mail

Address 3191 Lesslie Hwy City Rock Hill

State S.C. Zip Code 29730 e-mail _____

Phone (803) 324-0828 Ext. _____ Fax ( ) _____ ☐ check if confidential fax

Billing address **(only if different than above):** Company or WC Insurance Carrier Lesslie Fire Department

Address _____ City _____ State _____ Zip _____

Attn: _____ Phone ( ) _____ Fax ( ) _____

If billing to carrier: Policy # _____ Effective Dates of Policy ___/___/20___ to ___/___/20___

South Carolina Department of Labor, Licensing and Regulation
Division of Fire and Life Safety • Office of State Fire Marshal
141 Monticello Trail Columbia, S.C. 29203
Phone: 803-896-9800 • www.scfiremarshal.llronline.com

Firefighter Registration
Name Based Criminal Records Check Request

The "South Carolina Firefighters Employment and Registration Act" requires a criminal records check prior to employment of a paid or volunteer firefighter. No later than 60 days after the start of his employment date as a paid or volunteer firefighter, each firefighter must be registered with the Office of the State Fire Marshal (OSFM) by his fire chief or other employer. The criminal background check must be conducted before registration.

After June 30, 2001, a person may not perform firefighting duties in South Carolina if the person has been convicted of, or pled guilty to, or pled nolo contendere to; (a) a felony; (b) arson or another offense provided in Article 3, Chapter 11 of Title 16; or (c) an offense involving a controlled substance as provided for in Chapter 53 of Title 44. The prohibition applies for 10 years after the conviction or plea of guilty or nolo contendere.

After the expiration of the 10-year period, a fire chief or other employer may determine whether to allow a person with a criminal record to perform firefighting duties; except no person may volunteer as a firefighter, be employed as a firefighter, or perform firefighting duties if he has been convicted of, pled guilty to, or pled nolo contendere to arson.

A firefighter who works for or serves more than one fire department must be registered by each department. A firefighter previously registered with the Office of the State Fire Marshal, but not actively engaged with a fire department or as a firefighter for a period of six months, must apply for registration and must submit a criminal records check. Firefighters that are being reinstated to their last registered department within a period of not more than three years are exempted.

If a firefighter becomes separated from employment or membership or becomes inactive, the fire chief or other employer within 60 days must notify the OSFM of the firefighter's separation or inactive status. Notification of separation of a firefighter from employment must be on a form as provided by the OSFM.

This does not apply to individuals engaged in firefighting duties during a declared state of emergency.

Note: This criminal records check request should be completed only on the firefighter being hired, and is not to be used as a screening tool. Accountability for these requests will be based on Firefighter Registration Records. Missing information may result in a background check that cannot be completed.

BACKGROUND REQUEST FOR: Request Date: _____

Name: _____ _____ _____
First Middle Last

Also know as and/or maiden name(s): _____

Gender: ☐Male ☐Female **SSN:** _____ **Date of Birth:** _____

Write clearly

REQUESTED BY: Fire Chief ☐ or Other Employer ☒

The fire chief or other employer must ensure that a prospective firefighter undergoes a criminal record check conducted by a law enforcement agency. A **"fire chief"** means the highest ranking officer or official in charge of a fire department, whether or not called by some other title. An **"employer"** means any fire department or other entity which puts an individual or employee in service as a firefighter or assigns any person to work or to official duties as a firefighter whether or not the firefighter receives financial compensation.

Name: Douglas R. Morris martha.simpson@yorkcountygov.com
Email to forward OSFM response and future information

Department: Lesslie Fire Dept. FDID#: 46209

Phone: 803-324-0828 Fax: _____

Mailing Address: 3191 Lesslie Hwy
Rock Hill, S.C. 29730

Rev: 04/04/12

South Carolina Firefighter Registration Form

South Carolina State Fire Marshal's Office
141 Monticello Trail
Columbia, South Carolina 29203

A. Name: _____
Last First Middle

Home Address _____

Social Security Number: ___-___-___ Date of Birth: ___/___/___
Month Day Year

Driver's License Number: _____ State: _____ Class D/L: (Circle One) A B C D E F M G

Name of Employing Fire Department: Lesslie Fire Department

Fire Department Mailing Address: 3191 Lesslie Hwy

City: Rock Hill Zip Code: 29730 FDID #: 46209

Telephone Number: (803)-324-0828 Status: ____Paid X Volunteer

☐ Background Check Completed
Date: _____
(Necessary if Employed On or After July 1, 2001)

☐ Employed Prior to July 1, 2001
Employment Date: _____

Chapter 80, South Carolina Code of Laws.

Tommy White
Fire Chief (Print Name) Date

Tommy White
Fire Chief (Signature) Date

B. **ACTION TAKEN**
(For All Actions Taken On or After July 1, 2001)

Please Check

____	Employment Date (See Section 40-80-10.B.2)	Effective Date: _____
____	Termination	Effective Date: _____
____	Voluntary Separation	Effective Date: _____
____	Retirement	Effective Date: _____
____	Inactive	Effective Date: _____
____	Member of Multiple Departments – List:	_____
____	Other (Explain)	_____

C. **Do Not Write Below This Line**
(For SCFM Use Only)

The named individual _____ is

☐ Registered as a firefighter in the State of South Carolina

Registration Number: _____ Date: _____

☐ Denied registration based on: _____

_____

FR1 7/1/01

_____
Authorized Signature

Individual Member Application
South Carolina State Firefighters' Association
(Please Type or Print Clearly)

First Name, Middle Initial, Last Name _____ Rank _____

Home Address _____ City, State, Zip Code _____

Home Telephone _____ Cell or Business Telephone (Circle one Please) _____ E-Mail Address _____

York Department County | Lesslie Fire Department Fire Department Name | 46209 FDID#

Drivers License # _____ Date of Birth _____ Date of Hire _____

Firefighter Status: Paid_____ Volunteer_X_ Retired_____

Race _____ Sex _____

Membership Type: Regular ($35)_X_ Associate ($35)_____

Life ($26)_____ Past Pres. Life ($26)_____

Dues Amount Paid _____

Transferred From Another Department: Yes _____ No _____

Department Name_____

Is this member replacing another member from your department: Yes ___ No ___

Name of member they are replacing: _____

(If a termination form has not been sent in for the member being replaced, please submit one with this application).

South Carolina State Firefighters' Association

Designation of Beneficiary Form

Department: Leslie Fire Department

Member Name: _____

Address: _____

_____

SS#: _____ Date of Birth: _____

Marital Status: _____ Sex: _____

Primary Beneficiary Name: _____

SS# _____ Date of Birth: _____

Relationship: _____ Telephone: _____

Address: _____

Second Beneficiary Name: _____

SS# _____ Date of Birth: _____

Relationship: _____ Telephone: _____

Address: _____

_____ _____

Member's Signature Date

PLEASE MAINTAIN THIS FORM AT FIRE DEPARTMENT

County

SOUTH CAROLINA STATE FIREFIGHTERS' ASSOCIATION

SOUTH CAROLINA STATE FIREFIGHTERS' ASSOCIATION
RETIREMENT PLAN AND TRUST
LENGTH OF SERVICE AWARDS PROGRAM FOR VOLUNTEERS

DESIGNATION OF BENEFICIARY FORM

DEPARTMENT: Lesslie Fire Dept.

PARTICIPANT NAME: _____

Address: _____

_____

Social Security Number: _____

Date of Birth: _____

Continuously Employed Since: _____

Marital Status: _____ Sex: _____

( ) Married Participant

I understand that the death benefit must be paid to my surviving spouse, unless my spouse consents in writing to an alternative beneficiary. The Fire Department has provided me with a detailed explanation of the rights concerning the death benefit (PRE-RETIREMENT SURVIVOR BENEFIT EXPLANATION and ELECTION TO WAIVE PRE-RETIREMENT SURVIVOR WITH SPOUSAL CONSENT).

I understand that I must immediately inform the Fire Department of any change in my marital status.

Understanding my options, I choose to:

(1) ( ) Keep my spouse as primary beneficiary. But if my spouse does not survive me, I name as contingent beneficiary(ies):

_____ _____

Spouse Social Security Number

(2) ( ) name someone other than my spouse as the primary beneficiary. I understand that my spouse must agree to this waiver.

(1) Primary Benefiiary(ies): Relationship

SS#_____ _____

_____ _____

_____ _____

(2) Contingent Beneficiary(ies) Relationship

SS# _____ _____

_____ _____

_____ _____

(3) ____, I desire to name the South Carolina State Firefighters' Association Endowment as a contingent beneficiary for _____% of my account if none of the above named beneficiaries are alive.

EXECUTED this _____ day of _____, 20____.

_____
Witness

_____
Signature of Participant

_____
Birth Date

_____
Social Security Number

( ) UNMARRIED PARTICIPANT

I designate as beneficiary the person(s) named below. However, if I thereafter marry, this will revoke the designation. I will therefore immediately inform the Fire Department of any change in my marital status.

(1) Primary Beneficiary(ies) Relationship

SS#_____ _____

_____ _____

_____ _____

(2) Contingent Beneficiary(ies) Relationship

SS#_____ _____

_____ _____

_____ _____

(3) _____, I desire to name the South Carolina State Firefighters' Association Endowment as a contingent beneficiary for _____% of my account if none of the above named beneficiaries are alive.

EXECUTED this _____day of _____, 20_____.

_____ _____

Witness Signature of Participant

_____

Birth Date

_____

Social Security Number

ELECTION TO WAIVE PRE-RETIREMENT SURVIVOR BENEFIT

Participant: _____

As a Participant in the South Carolina State Firefighters' Association Retirement Plan hereby acknowledge that I have been informed by the Plan Administrator that if I should die prior to my retirement, my spouse and I have the right to have the full account balance under the Plan paid to my spouse; that I have the right to waive the designation of my spouse as the sole direct beneficiary of my death benefit only if my spouse consents to such waiver; and that I have the right to revoke such waiver which may be made by me at any time without my spouse's consent.

I herby waive the right to have my spouse be the sole direct beneficiary of my pre-retirement death benefit. I designate the following beneficiary in lieu of my spouse (revoking any prior designation or contingent designation made by me):

Designated Beneficiary: _____

_____

_____

If living at the time of my death, or, if not living, then

_____

EXECUTED this _____day of _____, 20____.

_____ _____

Witness Signature of Participant

PRE-RETIREMENT SURVIVOR BENEFIT EXPLANATION

Participant: _____

Department Name: Lesslie Fire Dept

This form explains the pre-retirement death benefit under the Plan. The pre-retirement death benefit provides a benefit for your surviving spouse if you die prior to distribution from the Plan. The surviving spouse will be entitled to 100% of your account balance. You need to read the balance of this explanation only if you have designated, or wish to designate someone other than your spouse to receive 100% of your account balance under the Plan.

Pre-retirement death benefit. If you are married at the time of your death, then the Plan requires the Trustee to distribute your account balance to your surviving spouse if your death occurs prior to commencement of benefits under the Plan and your spouse survives you. Generally, the Trustee may not commence payment of the pre-retirement death benefit prior to the date you would have attained the later of Normal Retirement Age under the Plan or age 62 without the consent of your surviving spouse. However, your surviving spouse may elect to have distribution of the pre-retirement death benefit at any time following your death.

If you are not married at the time of your death, then the death benefit will be paid to your designated beneficiary.

Waiver Election. The plan requires payment of the pre-retirement death benefit to your surviving spouse unless you have a valid waiver election in effect on the date of your death. To have a valid waiver you must complete the waiver election form enclosed with this explanation. Your waiver election is not valid unless your spouse also consents in writing to your beneficiary designation or to any change in your beneficiary designation, unless your spouse is the sole primary beneficiary. A notary public or Plan representative also must witness your spouse's consent to the beneficiary designation. You may revoke a waiver election without your spouse's consent, but your spouse would have to consent to a new waiver. A waiver election is valid only for the spouse consenting to the waiver. Therefore, you should inform the Plan Administrator of any change in your marital status.

Procedure. If you wish to have the pre-retirement death benefit distributed to your surviving spouse, you do not need to make any election. If you wish to have the pre-retirement death benefit distributed to someone other than your surviving spouse, execute the enclosed ELECTION TO WIAVE PRE-RETIREMENT SURVIVOR BENEFIT and SPOUSE'S CONSENT TO WAIVER OF THE PRE-RETIREMENT SURVIVOR BENEFIT forms. We also have enclosed a DESIGNATION OF BENEFICIARY form.

If you have any questions regarding the information provided in this explanation, or you wish further information, please contact the Plan Administrator.

_____ _____

Date Signature of Plan Administrator

SPOUSE'S CONSENT TO WAIVER OF PRE-RETIREMENT SURVIVOR BENEFIT

I _____ , spouse of _____,
Hereby consent to the designation made by my spouse to have the pre-retirement death benefit paid to the named beneficiary specified in the foregoing election. Further, I hereby acknowledge that I understand (1) that the effect of such designation is to cause my spouse's death benefit to be paid to a Beneficiary other than me in the form specified therein; (2) that such beneficiary designation is not valid unless I consent to it; and (3) that my consent is irrevocable unless my spouse revokes the beneficiary designation.

EXECUTED this _____day of _____, 20_____.

_____
Signature of Participant's Spouse

Witness by Plan Representative.

Signature of spouse witnessed this _____day of _____, 20_____.

_____
Plan Representative

Or

Witness by Notary.

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned, a Notary Public, personally appeared _____who executed the above spouse's consent as a free and voluntary act.

IN WINESS WHEREOF, I have signed my name and affixed my official notarial seal this _____day of _____, 20_____.

(SEAL)

Notary Public _____

My Commission Expires: _____

VFIS®

Beneficiary Designation for Accident & Sickness Policy

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

Name of Organization Lesslie Fire Department State S.C.

Member's /Employee's Name _____

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

Complete, sign and date this block 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 refer to back of form 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** _____

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.

C01:008A

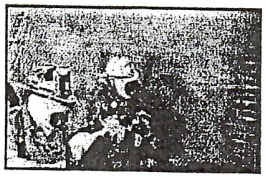
Benefit Summary for
York County Volunteer Fire Departments

- Accidental Death Benefit of $20,000, *24 hour coverage*
    - Additional Accidental Death Benefit of $20,000 for covered activities

- <u>Covered Activity Benefits for the membership</u>:
    - Loss of Life Benefit / $20,000
        - Seat Belt Benefit $5,000
        - Dependant Child Benefit $10,000
        - Spousal Support Benefit $5,000
        - Memorial Benefit for ESO $2,000
    - Living Benefits
        - Coverage provided for Heart Attack / Circulatory Malfunction
        - Supplemental Disability Benefit
            - Up to $400 per week income replacement
        - Lump Sum Living Benefits / Based on $20,000 ADD
            - Accidental Dismemberment
            - Vision Impairment
            - Injury / Illness Permanent Impairment
            - Permanent Physical Impairment
            - Burn Benefit Heart Permanent Impairment Benefit
            - Illness Permanent Impairment Benefit
        - Cosmetic / Plastic Surgery Benefit / up to $10,000
        - Critical Incident Stress Management Expense / up to $2,500
        - Post-Traumatic Stress Order Benefit / up to $10,000 per person
        - HIV Positive Benefit $20,000 Post-exposure Protocol Expense / up to $2,500
        - Accident Medical Expenses – Excess Coverage / up to $20,000
        - Family Medical Expense $100 per day / $50 per day outpatient
        - Occupational Retraining Benefit up to $20,000
        - Continuation of Medical Insurance Premium Benefit up to $12,000
        - Transition Benefit
        - Heart Permanent Impairment Benefit
        - Felonious Assault Benefit
        - Vehicle / Home Modification Benefit
        - And more

What is a Covered Activity?

Firefighting
Classroom Training
Rescue Operations
Emergency Duties
Monthly meetings



Training Exercises
Firematic Events or Contests
Ambulance Runs
Fund Raising
Conventions

Also includes Travel <u>TO and FROM</u> these covered activities

Coverage is written in Excess of Worker's Compensation
This is a summary only. Please refer to Department Policy for detailed information.
For additional information: Darrell Hood - Correll Insurance Group - 1-800-497-0098