



South Onondaga Fire Department
Length of Service Award Program (LOSAP)

NEW MEMBER FORM

The Town of Onondaga is the sponsor and administrator of a Length of Service Award Program (known as a "LOSAP") for Active Members of the South Onondaga Fire Department. Firefly Admin Inc. assists the Town with the administration.

In order to participate in the LOSAP and earn a benefit, you must be over age 18 and earn 50 points under the Point System in a calendar year. With this New Member Form, you have been provided with a Beneficiary Designation Form, a copy of the Point System and the Plan Summary. The Plan Summary will give you details about the benefits you can earn, the vesting schedule, and other important details. Please read it carefully. These documents can be accessed on-line at: www.FDLOSAP.com/SOFD34048.

Completing this form does not mean you will be eligible for a benefit from the Program. However, since the purpose of the LOSAP is to provide cash payment once certain eligibility requirements are met, the Town must receive all the information requested on this form. If you do not wish to participate in the LOSAP you may waive your right to participate; contact the Fire Department or Town for that form or obtain one at the web address noted above. The Town Board will not approve your application for active membership without a completed New Member Form and a completed Beneficiary Designation Form, or a Participation Waiver.

All information provided will be used by the Town and Firefly Admin Inc. for the exclusive purposes of the LOSAP. Your personal information will not be released to any third party unless we are required to provide some or all of it to the IRS or the financial institution which will pay LOSAP benefits to you or your beneficiary, or if you authorize the release of the information.

Any questions relating to the Program should be directed to the Town Clerk or the Fire Department. Please **PRINT** clearly and keep a copy for your records.

1. New Member Information

Name: _____ SSN: _____

Mailing Address: _____

Birthdate: _____ Start/Join Date: _____

Phone: _____ Email: _____

If you were formerly a volunteer firefighter in one of the eight Town Fire Departments, please enter the Fire Dept. and dates of service: _____

2. Acknowledgement

I hereby certify that: (1) the information I provided above is true and accurate; (2) I have received the Plan Summary and Point System; (3) I agree to participate in the LOSAP in accordance with the Plan Summary, Point System, and other governing documents, rules, and laws; (4) no tax or legal advice has been given to me by either the Town of Onondaga or Firefly Admin Inc. regarding my participation in the LOSAP; and (5) I accept the responsibility to seek my own tax and legal advice regarding the possible cash payment(s) I may receive after meeting the eligibility requirements.

Signature

Date

The purpose of this form is to name the individual(s) you wish to receive any death benefit that may be payable from the LOSAP. New York State Law stipulates that if no beneficiary is named, or if you outlive all your beneficiaries, any death benefit must be paid to your estate. Completing this form does not guarantee that a death benefit will be payable.

This form will supersede any previous designation on file. Before naming your estate or a minor child as a beneficiary, it is strongly suggested that you seek legal advice. Death benefits cannot be paid directly to a minor child.

Please **print clearly** using only blue or black ink (not pencil or any other color) and **keep a copy for your records**. Provide all information requested for each beneficiary; however, SSN is optional for beneficiaries.

YOUR BASIC INFORMATION

Circle One: Initial Designation Change in Designation	Name	SSN	Birthdate
	Mailing Address	Phone	
		Email	

PRIMARY BENEFICIARIES The following Primary Beneficiary(ies) will receive any LOSAP death benefit payable. The total death benefit will be allocated to each Primary Beneficiary based on the *Share Percentage* indicated below. If the total of all Primary Beneficiary Share Percentages is not 100%, this form is not valid. If a Primary Beneficiary dies before you, surviving Primary Beneficiaries will be paid proportionally to their Share Percentage.

Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	
Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	

Total 100% *If you wish to name more than two Primary Beneficiaries, please attach a signed addendum.*

CONTINGENT BENEFICIARIES If your Primary Beneficiary(ies) die before you, the following Contingent Beneficiaries will receive any LOSAP death benefit payable. If the total of all Contingent Beneficiary Share Percentages is not 100%, this form is not valid. If a Contingent Beneficiary dies before you, surviving Contingent Beneficiaries will be paid proportionally to their Share Percentage.

Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	
Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	
Share %	Name	SSN (optional)	Birthdate
	Mailing Address	Phone	Relationship
		Email	

Total 100% *If you wish to name more than three Contingent Beneficiaries, please attach a signed addendum.*

SIGNATURE

This form must be signed and dated to be valid:

Signature

Date