

**Pacific Service Employees Member Disability Plan
Application for Membership**

For PSEA Office Use Only

Admission fee of \$1.00 received

Date _____ By _____ Contributions _____

Approved by the PSEA Board of Directors effective _____

Full Name _____
(Type or Print) Last First Middle

Social Security Number _____ Date of Birth _____ Date of Employment _____
Month/Day/Year Month/Day/Year

Division _____ Department _____ Location _____

Home Address

_____ No. and Street City State Zip

1. Have you, within the past two years, had any illness, disease or injury which prevented you from working? _____
Give particulars _____
2. Have you been advised to have a surgical operation during the past two years? _____
If yes, what type of surgery? _____
Was surgery performed? _____ If yes, when? _____
3. Do you know of any impairments now existing in your health or physical condition? _____
If yes, give particulars _____
4. Are you a new hire rehire returning from a leave of absence. If a personal leave of absence, return to work date _____
5. Do you represent each and all of the foregoing to be true and complete? _____

Signature of Applicant _____ Date _____

Please read reverse side carefully and sign

APPLICATION FOR MEMBERSHIP

I, the undersigned, now employed by Pacific Gas & Electric Company, or its domestic subsidiaries and affiliates, or Pacific Service Employees Association, and being a member in good standing in the Pacific Service Employees Association, do hereby apply for membership in the Disability Plan and consent and agree to be bound by the provisions of said Disability Plan and its rules and regulations now in force, and by any other rules or regulations of said Disability Plan hereafter adopted and in force during my membership.

I also agree, request and direct that said Company by its proper agents, and in the manner provided for in the Disability Plan, shall during my membership therein, deduct from any wages earned by me under employment by said Company and pay to the Treasurer of the Pacific Service Employees Benefit Association for the account of the Disability Plan any and all assessment duly and regularly levied by the Board of Directors in the same manner as I have directed the payment of any monthly voluntary contributions.

Should I desire to terminate my membership in the Disability Plan, I agree to notify the Secretary of the Disability Plan, or his designated agent, to this effect in writing at least thirty (30) days prior to the date upon which I desire my membership to terminate..

I agree that this application, upon approval, shall make me a member of the Disability Plan on and from the date specified in such approval, and that such membership shall not be voided by any change in the amounts deductible from my wages and payable to the Disability Plan, and that the agreement that the above named amount shall be deducted from my wages shall apply also to any other amounts (whether for contributions or assessments) which I may become obligated to pay pursuant to the provisions of the Disability Plan, or its rules and regulations now in force and effect or hereafter adopted..

I also agree, for myself and those claiming for or through me, to be governed by the provisions of the Disability Plan providing for the final and conclusive settlement of all claims and benefits, or controversies of whatever nature, by reference to the Administrative Officer and an appeal from the decisions of said Administrative Officer, as in said Disability Plan provided, without recourse to a court of law or equity.

I certify that I am temperate in my true habits: that, so far as I know, I am now in good health.

I also agree that any untrue or fraudulent statements made by me, or any concealment of facts in this application or any attempt upon my part to defraud or impose upon said Disability Plan, or my resigning from or leaving the Service of the Company, my being relieved or discharged therefrom, or pensioned, or my failure to be and remain a member in good standing in the Pacific Service Employees Association, shall forfeit my membership in the Disability Plan and any and all rights, benefits and equities arising therefrom.

Date _____ Signature of Applicant _____

Admission Fee \$1.00

Contributions of \$5.00 monthly payable in advance by payroll deduction.

NOTE: If you have been in the employ of the Company for more than two (2) years, a "Medical Examiner's Certificate" (Form 94-319) is required to be completed and forwarded with this application.