Good Will Fire Company #2
552 East Union Street
West Chester, PA 19380
610-431-4366 (Business/Voice mail)
610-431-6528 (Fax)
www.goodwillfireco.org

APPLICATION FOR MEMBERSHIP

Date: _____

Desired Membership Type:

___ Active Firefighter ___ Active Contributing

Full Name: _____
Address: _____
_____
E-mail Address: _____
Phone Number: ( )_____
Cell Phone #: ( )_____
Work Phone #: ( )_____
Social Security Number: _____
Driver's License #: _____
License Plate # and State: _____

Permanent Address: _____
_____
Date of Birth: _____
Are you under the age of 18? **Yes No
School_____
Occupation: _____
Employer: _____
Work Address: _____
_____

Proposed by: _____ Date of proposal: _____
(Must be a member in good standing)

Previous Firefighting experience (List companies, positions held, and reason for leaving): _____
_____
_____

List any Fire/EMS training (Attach certificates if possible): _____
_____
_____

Special qualifications or jobs skills: _____
_____
_____

References (May include only **one member** of the Good Will Fire Company and an employer, do not use a relative): Include name, address, and phone number.

1._____ Phone: _____
2._____ Phone: _____
3._____ Phone: _____

Are you currently a member of another company in the West Chester Fire Department? Yes No
If YES, please complete the below area:

First West Chester Fire Co.: _____ Membership Type: ___ Active firefighter ___ Social

Fame Fire Co.: _____ Membership Type: ___ Active firefighter ___ Social

Note: You cannot be an active firefighter with more than one West Chester company at the same time.

Have you ever been convicted of an offense or crime or are you now charged with any offense or crime? (except for traffic offences/parking tickets): Yes No

If YES, please provide additional information below.

Additional Information:

Please list all address where you have resided during the past 7 years. If you need require more space please attach additional sheet(s).

Any information contained in this application that is found to be false is grounds for immediate dismissal from the Good Will Fire Company #2. All statements are subject to investigation, including a check of police records/criminal history information and a reference check.

CERTIFICATION: I *certify* that ALL of the statements made on this application are true, complete, and correct to the best of my knowledge, and were made in good faith.

_____ Date: _____

Signature of Applicant (In Ink)

A **non-refundable $20.00** application fee is due with submission of this application. The application fee will cover your first year dues if you are found favorable. Annual dues after initial application are $10.00 per year.

The applicant or the recommending member must be present at the monthly meeting when the applicant is proposed or the monthly meeting when the applicant is voted on.

Any applicant **under 18 years of age must furnish working papers and have a parent or guardian sign the permission form provided by the Electing Committee.

Active Members Must Complete Following Affidavit

By signing below the applicant swears or affirms the following:

I have never been convicted of an offense that constitutes the crime of "arson and related offenses" under 18 Pa.C.S. § 3301 or any similar offense under any Federal or State law. I hereby certify that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein, I am subject to penalties prescribed by law, including, but not limited to, a fine of at least $1,000.

_____ _____

Signature of Applicant Date

_____

Printed Name of Applicant

Beneficiary Information

Instructions

The following two forms must be completed and submitted with the membership application. These forms designate beneficiaries for any insurance payments that the member may be eligible for under the insurance policies that the company has in effect. The member should review the insurance policies and familiarize themselves with the coverage that is provided.

24-Hour AD&D Beneficiary Designation Form

Please complete this form and return it to your organization's Secretary who should maintain this form with your emergency service organization's records. Please do not return this form to Provident. If necessary, please photocopy this page or print additional copies at www.providentbenefits.com. Please PRINT or TYPE.

Policyholder Name (Emergency Service Organization) _____ Policy # _____

Insured Person's Last Name _____ First _____ Initial _____ Date of Birth _____

Insured Person's Street Address _____

Insured Person's City _____ State _____ Zip Code _____ Social Security # _____

Primary Beneficiary ~ If the benefit is to be paid to more than one person, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each primary beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all primary beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Contingent Beneficiary ~ The contingent beneficiary(ies) will only receive benefits if all named primary beneficiaries predecease the Insured Person. If the benefit is to be paid to more than one contingent beneficiary, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each contingent beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all contingent beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Insured Person's Signature _____ Date Signed _____

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Please return this form to your organization's secretary where it should be maintained with your emergency service organization's records.

Provided by: Provident Agency, Inc.
Toll Free 800.447.0360

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Accident & Health Beneficiary Designation Form

Please complete this form and return it to your organization's Secretary who should maintain this form with your emergency service organization's records. Please do not return this form to Provident. If necessary, please photocopy this page or print additional copies at www.providentbenefits.com. Please PRINT or TYPE.

Policyholder Name (Emergency Service Organization) _____ Policy # _____

Insured Person's Last Name _____ First _____ Initial _____ Date of Birth _____

Insured Person's Street Address _____

Insured Person's City _____ State _____ Zip Code _____ Social Security # _____

Primary Beneficiary ~ If the benefit is to be paid to more than one person, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each primary beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all primary beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Contingent Beneficiary ~ The contingent beneficiary(ies) will only receive benefits if all named primary beneficiaries predecease the Insured Person. If the benefit is to be paid to more than one contingent beneficiary, please list the names, dates of birth, and Social Security #'s, and indicate the relationship to the Insured Person, as well as the percentage each contingent beneficiary should receive. If percentage shares are not given, they will be equal. Total percentage for all contingent beneficiaries must equal 100%.

Name	Date of Birth	Social Security #	Relationship	% Share

Insured Person's Signature _____ Date Signed _____

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Please return this form to your organization's secretary where it should be maintained with your emergency service organization's records.

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Toll Free 800.447.0360

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