



**Retired Police Association**  
**of the State of New York, Inc.**  
1 Old Country Road, Suite 276, Carle Place, New York 11514-1884  
Phone (516) 294-4488 Fax (516) 294-5129

**MEMBERSHIP APPLICATION**

DATE OF APPLICATION: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
First (MI) Last Month/Day/Year

ADDRESS: \_\_\_\_\_  
Number Street Apt #

CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: +FOUR: \_\_\_\_\_

HOME TELEPHONE: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

ALTERNATE CONTACT NAME OTHER THAN BENEFICIARY: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Number Street Apt # City State Zip

**RETIREMENT INFORMATION**

DEPARTMENT/AGENCY \_\_\_\_\_

RETIRED FROM: \_\_\_\_\_ TELEPHONE: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RETIREMENT PENSION #: \_\_\_\_\_  
Number Street Apt # City State Zip

SERVICE DATES FROM: \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_ RETIREMENT SYSTEM: \_\_\_\_\_

REASON FOR RETIREMENT: \_\_\_\_\_ (Service/Disability/Vested)

SIGNATURE OF APPLICANT: \_\_\_\_\_

**COMPLETE ABOVE INFORMATION AND AFFIX SIGNATURE**

DUES \$45.00 PER YEAR CHECK #/CASH: \_\_\_\_\_ AMOUNT: \$ \_\_\_\_\_

\_\_\_ FINANCIAL SECRETARY: \_\_\_\_\_ DATE RECEIVED: \_\_\_\_\_

DATE APPROVED: \_\_\_\_\_ DATE DISAPPROVED: \_\_\_\_\_

RECORD #: \_\_\_\_\_ ENTERED/COMPUTER: \_\_\_\_\_ BENEFICIARY CARD: \_\_\_\_\_

(OVER)

**REQUIREMENTS FOR ADMISSION TO THE  
RETIRED POLICE ASSOCIATION OF THE STATE OF NEW YORK, INC.**

**ART. IV DEFINITIONS**

**POLICE OFFICER:** For the purpose of this Constitution and By-Laws, the term "Police Officer" shall mean a Police Officer as defined in Section 1.20, Subd. 34 of the Criminal Procedure of Law of the State of New York.

**RETIRED POLICE OFFICER:** Notwithstanding any provision of any law, rule or regulation of the State of New York, or any organization or association legally constituted therein, the definition of "Retired Police Officer" for the purpose of membership in this Association shall include, and shall only include persons who were Police Officers as defined herein and who have been employed and honorably retired from a law enforcement agency of the State, County, Town, City, Village, Public Authority, or Police District within the confines of New York State.

**ART. V MEMBERSHIP:**

**1 A (1) ACTIVE MEMBERS**

Any person, male or female, who served as a Police Officer as the term "Police Officer" is defined in Section 1.20, Subd. 34 of the Criminal Procedure Law of the State of New York, and

who has retired after having served honorably as a Police Officer in any law enforcement agency of the State, County, Town, City, Village, Public Authority, or Police District within the confines of New York State, or

while serving honorably as a Police Officer of a law enforcement agency as described herein, is discharged under honorable conditions as disabled or unfit for duty because of an on or off-duty injury or illness,

is eligible for membership in this Association.

HAVING READ THE REQUIREMENTS FOR MEMBERSHIP TO THE RETIRED POLICE ASSOCIATION OF THE STATE OF NEW YORK, INC., AND COMPLETED THE APPLICATION FOR MEMBERSHIP, I AFFIRM THAT I QUALIFY FOR MEMBERSHIP AS A RETIRED POLICE OFFICER AND THAT I FULFILL THE REQUIREMENTS FOR ACTIVE MEMBERSHIP AS DESCRIBED HEREIN, AND THAT MY APPLICATION FOR MEMBERSHIP IS TRUTHFUL, ACCURATE AND COMPLETE. FURTHER, I UNDERSTAND THAT ANY FALSE INFORMATION OR STATEMENT MADE ON THIS APPLICATION AND/OR FAILURE TO MEET THE REQUIREMENTS FOR MEMBERSHIP MAY BE CAUSE FOR REJECTION OR IMMEDIATE TERMINATION FROM THE ASSOCIATION.

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\*Signature

Date

**\*By signing this application, you verify that all the information provided  
is correct and that you have met the qualifications for membership in the RPA.**



Retired Police Association of the State of New York, Inc.  
Members Benefit Information Card



Member Name: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_

\_\_\_\_\_ Dept: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Last 4 of Social Security: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

On the reverse side of card, please fill out beneficiary's information, or sign for donating death benefit to scholarship program. **Only one choice can be made.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(over)

(A) Beneficiary Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Beneficiary Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Alternate Beneficiary Name: \_\_\_\_\_

Alternate Beneficiary Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

OR

(B) I, choose to donate my death benefit to the RPA Scholarship Fund in place of an individual beneficiary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Select A or B from above and complete)**