



CEMA/OE3 Membership Packet



County Employees Management Association (CEMA) is an association of managers, administrators, and supervisors employed by Santa Clara County, Monterey County, Santa Cruz County, and Santa Clara County Superior Court.

CEMA is fully affiliated with **Operating Engineers Local 3 (OE3)**, which represents nearly 40,000 private sector members and 10,000 public sector members (State, County, City, and other government workers).

Please complete the attached **Membership Application and Payroll Authorization** form to become a dues-paying member.

Once this form is complete, it will be forwarded to your HR department to process the payroll deduction of your dues. Please email membership@sccema.org if you do not see the payroll deduction on your paycheck after 2 pay periods.

CEMA/OE3 considers you a dues-paying member upon receipt of a complete and accurate membership application form.

OE3 has an optional \$2500 death benefit available to you while you are a dues-paying member.

The **Designation of Beneficiary** form can be completed and submitted with your membership application form.

Why be a Dues-Paying Member?

Learn more at www.sccema.org/membership

Dues-paying CEMA/OE3 members have access to professional services, union events, and information that empowers employees to continue to do outstanding work for the County.

Join a CEMA Committee!

Email membership@sccema.org to join.

Political Action Committee
Membership/Liaison
Professional Development
Communication



Dues-paying CEMA/OE3 members get exclusive news and updates through our email newsletter: **CEMA Voice**



@CEMAOE3



CEMA OE3



(408) 289-9691



www.sccema.org



help@sccema.org



County Employees Management Association
Serving Administrative and Supervisory Members Since 1974



MEMBERSHIP APPLICATION & PAYROLL AUTHORIZATION

APPLICANT

First Name	I	Last Name	Birthdate	Gender (M/F/Non-binary)	Social Security No.
Mailing Address			City	State	Zip Dist. 91
Telephone		Check the email address you prefer we use for CEMA business		Paperless Billing	
Home		<input type="checkbox"/> Email Work		<input type="checkbox"/> Yes	
Work		<input type="checkbox"/> Email Personal		<input type="checkbox"/> No	
Employee ID#	Position Title		Department Name & Number		Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No

PAYROLL AUTHORIZATION – CEMA

EMPLOYER: County of Monterey County of Santa Clara County of Santa Cruz Santa Clara County Superior Court

I hereby authorize the deduction of membership dues from my bi-weekly salary earned, the amount as agreed upon by the County Employees Management Association (CEMA) and Operating Engineers Local Union No. 3 AFL-CIO (Local 3) and pay same to CEMA affiliated with Local 3. The amount will be for association dues, Per Capita, membership initiation/dues and benefit programs of Local 3. This authorization shall be in full force and effect until revoked in writing to CEMA and the County of Monterey or the County of Santa Clara or Santa Cruz or Santa Clara County Superior Court.

I hereby authorize my Employer to withhold from my wages the current monthly dues rate set for my classification and to transmit said sum to Operating Engineers Local Union No. 3. I consent to the adjustment of such deduction (1) to conform to any future pay period change or (2) to reflect any change in fees of which the Employer may be advised by Operating Engineers Local Union No. 3. The authorization shall be in full force and effect until revoked by the undersigned or by Operating Engineers Local Union No. 3 consistent with the procedures set forth below.

I direct my employer to deduct from my pay regular amounts equal to the union's membership dues and to transfer that money to the union, regardless of my membership status. I understand that the union may periodically adjust the amount, per the Operating Engineers Local Union No.3 Bylaws. I understand that I can cancel my membership in the Union at any time, which must be done in writing. I understand that in the event that I cancel my membership, I will maintain my commitment to continue the payments equal to the union's dues for 12 months from my authorization date, the date I sign below, at which time my commitment will continue unless I revoke that commitment by giving the union a written notice, not less than ten (10) days and not more than twenty (20) days before the end of that 12-month period. I agree that the contributions authorized above shall continue and this authorization shall automatically renew annually. The revocation must be mailed to the union's central office.

I hereby swear under penalty of perjury that to the best of my knowledge all statements made on this questionnaire are true.

Applicant's Signature:

Date:

You may complete this application on paper and submit to membership@sccema.org.

IMPORTANT: We can only accept wet signatures, scans, or images of your signature. We cannot accept type or electronic signatures.

Please Note: If you have any questions or for future **address changes**, please contact the CEMA office at 408-289-9691 or membership@sccema.org.

<input type="checkbox"/> Beneficiary card received		ADMINISTRATIVE USE ONLY							
Hir	Ct#	Billing #	Ckoff Code	Dues Rate	App Dist	Type	Local	Old Local	
Register No	Init Loc	Init Date	Previous Membership Status	Comments					
TYPE OF APPLICATION: <input type="checkbox"/> New Member									

OPERATING ENGINEERS LOCAL NO. 3 BENEFICIARY DESIGNATION FORM (PART II)
(ALL BENEFITS EXCEPT PENSION AND ANNUITY PLANS)

DESIGNATION OF BENEFICIARY

**Fringe Benefit Office, 3920 Lennane Drive Suite 200, Sacramento, CA 95834
(510) 748-7450**

This form applies to the following benefits, as applicable:

1. OPERATING ENGINEERS LOCAL UNION 3 BURIAL BENEFIT
2. OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
3. OPERATING ENGINEERS HEALTH & WELFARE TRUST LIFE INSURANCE
4. HAWAII OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
5. HAWAII OPERATING ENGINEERS HEALTH & WELFARE TRUST LIFE INSURANCE
6. PENSIONED OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
7. OPERATING ENGINEERS PUBLIC & MISC HEALTH & WELFARE TRUST FUND BURIAL BENEFIT

1. YOUR
Info

LAST NAME		FIRST NAME IN FULL		MIDDLE NAME IN FULL	
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NO.		TELEPHONE NO.			
DATE OF BIRTH / /	CURRENT MARITAL STATUS (Please Circle One) Married Never Married Divorced Legally Separated Divorced & Remarried Widow(er)				
SPOUSE'S NAME (If Legally Married)			DATE OF MARRIAGE		
SPOUSE'S SOCIAL SECURITY NO.		IF DIVORCED OR LEGALLY SEPARATED, GIVE DATE (S)			

EXPLANATION REGARDING DESIGNATION OF BENEFICIARY

The term "Beneficiary" means a person (including a trust) designated by a Participant. You may designate the same person to receive all benefits named on the lower portion of this form, or different persons to receive each of them. If you list more than one beneficiary, they shall share the applicable benefits equally unless otherwise designated. You also may designate a contingent beneficiary to receive benefits in the event of the death of your primary beneficiary(ies). If you do not designate a beneficiary, then applicable benefits will be payable as provided under the Plan.

BE SURE TO COMPLETE THE ENTIRE FORM AND RETURN IT TO THE FRINGE BENEFITS OFFICE.

BENEFICIARY DESIGNATION

2. YOUR
Info

I, _____, Social Security No. _____ do hereby designate the following named person or persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death from all benefits payable from the above entities, as applicable. Part I must be completed to designate beneficiaries for the Pension Trust Fund for Operating Engineers, Operating Engineers Annuity Plan and the Hawaii Annuity Plan for Operating Engineers.

**Please note the following: a) if a trust is designated as beneficiary, please provide a complete copy of the trust document.
b) if multiple beneficiaries are desired, please provide as an attachment to this form.**

In the event of my death, pay any applicable benefits to:

3. BENE
Info.

PRINT NAME OF BENEFICIARY	SOCIAL SECURITY NO.	RELATIONSHIP	% of Distribution
ADDRESS		PHONE	
CONTINGENT BENEFICIARY	SOCIAL SECURITY NO.	RELATIONSHIP	% of Distribution
ADDRESS		PHONE	

4. DATE
&
SIGN

DATE: _____ SIGNATURE: _____