

ASBESTOS WORKERS LOCAL NO. 42 PENSION PLAN  
BENEFIT APPLICATION

**For Distributions Over \$1,000**

INSTRUCTIONS: Please read this application carefully and completely before answering any questions. Print your answers clearly. If any section of the application is not clear to you, please contact the Fund Office. Do not skip any questions or leave out any of the information requested. If a section does not apply, write "n/a" in the blank. When you have completed your application, mail it to the Fund Office with proof of age and, if applicable, proof of disability, marriage or divorce and/or property settlements, and military service.

<p><b>I. PERSONAL DATA</b> Include proof of age (i.e., a copy of your birth certificate) with your application.</p>	<p>Name _____  <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div> </p> <p>Social Security Number _____</p> <p>Address _____  <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Street</span> </div> </p> <p>_____ <span style="margin-left: 100px;">City</span> <span style="margin-left: 100px;">State</span> <span style="margin-left: 100px;">Zip</span></p> <p>Date of Birth _____ Telephone(____) _____</p> <p>Marital Status _____</p> <p>What date do you wish to be your <u>Annuity Starting Date</u>? _____</p>
<p><b>II. ELIGIBILITY</b> Check the <b>one</b> box at the right which applies to you.</p>	<p><input type="checkbox"/> You are at least age 55 and have retired.</p> <p><input type="checkbox"/> You are at least age 55 and have separated from Covered Employment.</p> <p><input type="checkbox"/> You are totally and permanently disabled. <u>If you have checked this box, complete Sections III of this application.</u></p> <p><input type="checkbox"/> You are under age 55 and have retired.</p>



Part A includes your declaration of marital status and, if married, your decision regarding spousal benefits (Check one box)

If you are **married AND if you are REJECTING the 50% Husband and Wife Annuity**, your spouse must complete the Spouse's Statement (Section IV.3)

If you are **not married**, you must complete the Statement by Unmarried Employees (Section IV.2)

**Part A** I declare as follows:

- I, \_\_\_\_\_, hereby state that I am not legally married at this time.
  
- I, \_\_\_\_\_, hereby state that I am unable to locate my spouse. (You must complete an additional form provided by the Fund Office.)
  
- I, \_\_\_\_\_, hereby state that I am legally married to the person co-signing this form, and I acknowledge that my benefit payment will be in the automatic form of a 50% Husband and Wife Annuity.
  
- I, \_\_\_\_\_, hereby state that I am legally married to the person co-signing this form and that I waive the payment of my Accumulated Share in the automatic form of a 50% Husband and Wife Annuity in favor of the optional form of payment I have elected in Part B below. I understand that unless I designate my spouse as my beneficiary in Part C below, he or she will not receive any benefit payable by the Fund upon my death. I understand that my waiver of the 50% Husband and Wife Annuity is not effective without the written consent, witnessed by a Notary Public, of the person to whom I am legally married, and that I may revoke my waiver at any time within the 90-day period before the benefit becomes payable. I further understand that I may not change my form of benefit or beneficiary(ies) without the consent of my spouse unless he or she expressly permits such designations without his or her written consent.

<p>Part B includes your election of an optional form of benefit payment if you are rejecting the automatic monthly benefit form.</p>	<p><b>Part B</b> After consideration of the optional forms of distribution of my Accumulated Share under the Asbestos Workers Local No. 42 Pension Plan, I reject the automatic lifetime monthly benefit (50% Husband and Wife Annuity if I am married or the Life Annuity if I am unmarried) and I elect to receive my Accumulated Share in the following form of payment: (check one)</p> <p><input type="checkbox"/> Single lump sum</p> <p><input type="checkbox"/> 75% Husband and Wife Annuity</p> <p>NOTE: If you did not check one of the boxes, your benefit will be paid in the appropriate automatic form.</p>								
<p>Part C includes your designation of beneficiary.</p>	<p><b>Part C</b> I hereby designate the following to receive the benefit, if any payable under the Plan upon my death:</p> <p>_____</p> <p>Primary Beneficiary</p> <p>_____</p> <table border="0"> <tr> <td>Name</td> <td>Birthdate</td> </tr> </table> <p>_____</p> <p>Address</p> <p>_____</p> <table border="0"> <tr> <td>Relationship</td> <td>Phone No.</td> </tr> </table> <p>_____</p> <p>Social Security No.</p> <p>In addition, I hereby designate the following person as my Contingent Beneficiary in case the Primary Beneficiary does not survive me. (A Contingent Beneficiary is entitled to receive benefits only if the designated Primary Beneficiary predeceases you.)</p> <p>_____</p> <p>Contingent Beneficiary</p> <p>_____</p> <table border="0"> <tr> <td>Name</td> <td>Birthdate</td> </tr> </table> <p>_____</p> <p>Address</p> <p>_____</p> <table border="0"> <tr> <td>Relationship</td> <td>Phone No.</td> </tr> </table> <p>_____</p> <p>Social Security No.</p>	Name	Birthdate	Relationship	Phone No.	Name	Birthdate	Relationship	Phone No.
Name	Birthdate								
Relationship	Phone No.								
Name	Birthdate								
Relationship	Phone No.								

**2. Statement by Unmarried Employees**

Complete this Section only if you are single, divorced, or widowed, or if you cannot locate your spouse.

If you were formerly married, you must provide the information specified for **each** marriage.

I hereby state that I am not legally married at this time. I also state that I have not lived with anyone under any circumstances constituting a common law marriage in a state that recognizes common law marriage.

Check the one statement that applies to you:

- I hereby state that I am not now, nor have I ever been married.
- I hereby state that I am unable to locate my spouse. (Additional proof will be required if you check this box.)
- I hereby state that I am not now married, but have been married and that the marriage(s) ended

by death \_\_\_\_\_ (provide date and attach copy of death certificate(s)).

by divorce \_\_\_\_\_ (provide date and attach copy of divorce decree(s)).

I recognize that the Fund may make inquiries about my marital status with various organizations and individuals and I consent to the release of any information about my marital status from my employers, my local and international union, any fringe benefit fund in which I may have participated, and any other organization or individual.

**3. Spouse's Statement**

Your spouse **must** complete Part A if you have waived the 50% Husband and Wife Annuity.

Spouse's Name \_\_\_\_\_

Spouse's Address \_\_\_\_\_

Spouse's Phone Number \_\_\_\_\_

Spouse's Social Security No. \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

Date of Marriage \_\_\_\_\_

**Part A** I swear that I am the legal spouse of the employee described above. I understand the Plan is obligated to pay retirement benefits of married participants in the form of a 50% Husband and Wife Annuity which would provide me with a monthly lifetime pension equal to 50% of the monthly pension payable to my spouse when living, if he or she dies before me. I also understand that my spouse has the right to waive this requirement if I consent to the waiver. I understand that the effect of the waiver is to cause me to give up this survivor protection and the pension paid to my spouse during his or her lifetime may be higher than if I had not consented to this waiver. Nevertheless, I hereby consent to the waiver of the 50% Husband and Wife Annuity and the election of \_\_\_\_\_ as the form of benefit payment to the employee.

**Part B** I understand further that my spouse may not name someone other than me as beneficiary to receive any benefit payable under the Plan in the event of my spouse's death unless I consent to the designated beneficiary or waive my right to do so. I therefore consent to the designation of \_\_\_\_\_ as beneficiary. Such designation may not be changed or revoked without my consent.

My consent is irrevocable unless my spouse revokes his or her waiver of the 50% Husband and Wife Annuity.

You **must** include your spouse's notarized signature. Do not leave any section blank.

\_\_\_\_\_  
Signature of Spouse \_\_\_\_\_ Date \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

On this \_\_\_\_ day of \_\_\_\_, 20 \_\_, before me, a notary public, came \_\_\_\_\_, known to me, who executed the foregoing in my presence.

Notary Public: \_\_\_\_\_ (Seal)  
Expiration Date: \_\_\_\_\_

OR

Plan Representative/Trustee: \_\_\_\_\_  
Date: \_\_\_\_\_

Your application will be submitted to the Trustees and you will be notified in writing of their decision.

You **must** include your notarized signature. Do not leave any Section blank.

I HEREBY apply for and consent to payment of benefits, to which I believe I am entitled, from the Asbestos Workers Local No. 42 Pension Plan. I certify that the information I have supplied herein is true to the best of my knowledge and I understand that any willfully false statement made by me in this application or any fraudulent information or proof I furnish will impede and/or delay my claim. I further understand that my eligibility for benefits is contingent upon my withdrawal from employment covered by this Plan.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

State of \_\_\_\_\_)

County of \_\_\_\_\_)

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, a notary public, came \_\_\_\_\_, known to me who executed the foregoing in my presence.

Notary Public: \_\_\_\_\_

(SEAL)

Expiration Date: \_\_\_\_\_

OR

Plan Representative/Trustee: \_\_\_\_\_

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

ASBESTOS WORKERS LOCAL NO. 42 PENSION PLAN

Rollover Election Form

Election or Rejection of Direct Rollover to an IRA or Retirement Plan

ATTENTION: BEFORE COMPLETING THIS FORM, YOU SHOULD READ THE SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS CAREFULLY. YOU ALSO MAY WISH TO CONSULT YOUR TAX ADVISOR BEFORE MAKING THIS ELECTION.

COMPLETE THIS FORM ONLY IF YOU WILL RECEIVE A PAYOUT IN A LUMP SUM, OR MONTHLY PAYMENTS SCHEDULED TO CEASE IN LESS THAN 10 YEARS FROM DATE PAYMENT BEGINS.

\_\_\_\_\_  
Participant's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Spouse-Beneficiary's Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

If you will receive part or all of your benefits as a lump sum (or monthly payments scheduled to cease in less than 10 years), that payment will be an "eligible rollover distribution". You may elect to have part or all of that distribution transferred directly to an Individual Retirement Account (IRA) or to another qualified retirement plan (if it accepts rollovers). If you choose not to have an eligible rollover distribution transferred directly to an IRA or other retirement plan, the Plan is required to withhold 20 percent of the payment for federal income taxes. This withholding does not increase your taxes, but will be credited against any income tax you owe. (For further information on direct rollovers and withholding, please read the Special Notice Regarding Plan Payments that the Plan has given you.)

If your benefit is more than \$500, you may choose to have only part of the payment directly rolled over, and to have the rest paid to you. Withholding will be taken out of any part that is not directly rolled over. If you want to have only part of your payment directly rolled over, please tell us the amount (at least \$500) that you would like to roll over.

If You Are An Employee Participant, Check A, B or C Below To Indicate Whether Or Not You Elect A Direct Rollover Of Your Pension Payment:

A. \_\_\_\_\_ I do not want to roll over any of my payment to an IRA or other qualified retirement plan. Pay me the full amount of my benefits, after withholding 20 percent for federal income taxes as required by law.

\_\_\_\_\_  
Participant's (or Spouse-Beneficiary) Signature

\_\_\_\_\_  
Date

B. \_\_\_\_\_ I want to roll over my payment directly to an IRA or other qualified retirement plan that accepts rollovers. The IRA or other retirement plan is named below.

C. \_\_\_\_\_ I would like to have only part of my payment directly rolled over. Please roll over \$\_\_\_\_\_ to the IRA or qualified retirement plan named below, and pay the remainder of my benefit to me, after withholding 20 percent for federal income taxes as required by law.

(OVER)



If You Are A Spouse-Beneficiary, Check D, E or F Below To Indicate  
Whether Or Not You Elect A Direct Rollover Of Your Pension Payment:

D. \_\_\_\_\_ I do not want to roll over any of my payment to an IRA. Pay me the full amount of my benefits, after withholding 20 percent for federal income taxes as required by law.

\_\_\_\_\_  
Participant's (or Spouse-Beneficiary) Signature      Date

E. \_\_\_\_\_ I want to roll over my payment directly to an IRA. The IRA or other retirement plan is named below.

F. \_\_\_\_\_ I would like to have only part of my payment directly rolled over. Please roll over \$ \_\_\_\_\_ to the IRA named below, and pay the remainder of my benefit to me, after withholding 20 percent for federal income taxes as required by law.

CERTIFICATION  
(COMPLETE *ONLY* IF ELECTING A DIRECT ROLLOVER)

If you have elected a direct rollover of all or part of your benefit, please read and sign the following statement:

I certify that the recipient of a direct rollover that I have named above is an Individual Retirement Account, an Individual Retirement Annuity, or a Qualified Retirement Plan that accepts rollovers. I understand that payment of my benefits to the trustee of the IRA or qualified retirement plan will release the Trustees of this Plan from any further obligations or responsibilities with respect to the benefits so paid.

Please make payment of my benefits on my behalf to:

\_\_\_\_\_  
Name of IRA Trustee or Qualified Retirement Plan

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Participant's (or Spouse-Beneficiary Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**If we do not receive this information within 45 days, the Plan will make the payments to you, after deducting the legally required withholding.**