

III. DISABILITY

You must attach medical evidence of your total and permanent disability to this application including a copy of any disability award you may have received.

1. Date you became totally and permanently disabled_____
2. Condition causing your total and permanent disability_____

3. Have you been granted a disability award from the Social Security Administration? Yes No
4. I hereby certify that as a result of an injury, disease, or mental disorder I am completely unable to engage in Covered Employment, and it is reasonably certain that my condition will continue during my remaining lifetime.

Signature of Applicant

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.