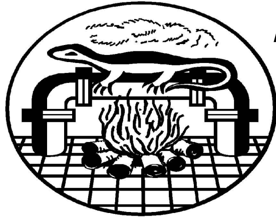
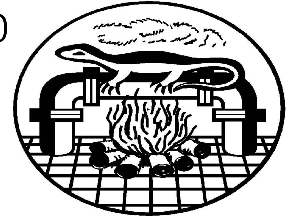


ASBESTOS WORKERS LOCAL UNION NO. 80 SUPPLEMENTAL PENSION PLAN



7130 COLUMBIA GATEWAY DRIVE, SUITE A
COLUMBIA, MARYLAND 21046

BENEFIT APPLICATION
For Distributions $5,000 and Under

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, please contact the Fund Office at 301-937-9300. 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.

1

INFORMATION ABOUT YOU - PERSONAL DATA

(Include proof of age, i.e. a copy of your birth certificate, with your application)

Name: ____
Last, First, Middle

Social Security Number: ________- _______ - ________

Address: ____
Street

____
City, State, Zip

Date of Birth: ________________________ Telephone: (____)__________________

Marital Status: ________________________

What date do you wish to be your **Annuity Starting Date?** ___________________________

2

REASON YOU ARE REQUESTING PENSION - ELIGIBILITY

(Check the **ONE** box below that applies to you)

❑ You are at least age 55 and have retired or are soon to retire. *If you have checked this box, complete Sections 4 and 5 of this application*.

❑ You have separated from covered employment and have not worked any hours for which contributions are required to be made to the Plan on your behalf for a period of at least six (6) consecutive months, and are not working in the United States or Canada, in the same industry and in the trade, craft or job of a type covered by the Plan. *If you have checked this box, complete Sections 4 and 5 of this application*.

2 - CONTINUED

REASON YOU ARE REQUESTING PENSION - ELIGIBILITY

❑ Your employer is no longer contributing to the Plan due to a change in the terms of the Collective Bargaining Agreement or the Participation Agreement, the cessation does not constitute a termination of the Plan, the employer has not contributed for a period of at least six (6) months, and you are not working in the United States or Canada in the same industry and in the trade, craft or job of a type covered by the Plan. *If you have checked this box, complete Sections 4 and 5 of this application*.

❑ You are totally and permanently disabled. *If you have checked this box, complete Sections 3, 4 and 5 of this application*.

❑ You are under age 55 and eligible for an immediate pension from the National Asbestos Workers Pension Fund or another pension plan maintained pursuant to a Collective Bargaining Agreement between your employer and the International Association of Heat and Frost Insulators or an Asbestos Workers Local Union. *If you have checked this box, complete Sections 4 and 5 of this application*.

3

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 any 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

4

PREVIOUS EMPLOYMENT INFORMATION - SEPARATION FROM COVERED EMPLOYMENT

1. Are you working now? ❑ YES ❑ NO

2. When did you retire or last work in any employment for which contributions were required to be made to this Fund on your behalf? ________________________________

3. Name and address of last contributing employer: ________________________________
____

4. Name and address of current employer, if any: __________________________________
____

5. Position with current employer, if any: ____

5

TYPE OF BENEFIT YOU ARE REQUESTING - BENEFIT ELECTION

❑ I elect to receive my lump sum distribution immediately. I understand that by receiving my distribution at this time, the distribution will include estimated interest paid since the last valuation (last fiscal year), and that I will give up my right to receive actual interest that would be payable for the current fiscal year. I also understand that this payment is final, and I cannot change my election at any time once this application is received by the Fund Office.

❑ I elect to wait until after the valuation is completed for the current fiscal year to receive my lump sum distribution. I understand that by waiting for my payout, I will be entitled to receive any interest accrued for the current fiscal year, and may need to file a new application to comply with the timing and notice requirements in Federal Regulations.

I HEREBY apply for and consent to payment of benefits, to which I believe I am entitled, from the Asbestos Workers Local Union No. 80 Supplemental 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: __________________________________

ASBESTOS WORKERS LOCAL UNION NO. 80
SUPPLEMENTAL PENSION PLAN

7130 COLUMBIA GATEWAY DR., SUITE A
COLUMBIA, MARYLAND 21046

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	

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 (20%) 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 (20%) for federal income taxes as required by law.

______________________________ ______________________

Participant's Signature (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 (20%) for federal income taxes as required by law.

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 (20%) for federal income taxes as required by law.

____ ____________________

Participants Signature (or Spouse-Beneficiary's Signature) Date

E. ❑ 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.

F. ❑ 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 (20%) 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 below 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 obligation 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's) 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.