Laborers' Trust Funds
7130 Columbia Gateway Drive
Suite A
Columbia, MD 21046
(410) 872-9500
(866) 553-6559 - Toll Free

APPLICATION FOR PENSION

(PLEASE PRINT ALL INFORMATION CLEARLY)

(Please read instructions before completing this application)

Enclosures: Procedures, Pension Application (1-12), Statement of Understanding (For Spouse of Retiring Member) (13-14), Direct Deposit Form (15-16), Retiree Medical Application (17), Pre-Retirement Health Checklist (18), Retiree MedicalCoverage Suspension Election (19) and Tax Form W-4P

Laborers' Trust Funds
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(866) 553-6559 - Toll Free

Procedure for Starting Your Pension Benefit

Before your pension payments can begin, you must complete the Pension Application Form and the Benefit Election Form and return them to the Fund Office.

The Benefit Election Form must be completed within the 90 day period ending prior to your Benefit Commencement Date ("Benefit Commencement Date" is the date you want your pension to start -- not the date you receive your first pension check, which is usually later than the Benefit Commencement Date due to the administrative processing in getting your benefit started; for a more complete description of this term, see the first page of the Benefit Election Form). If you complete the Benefit Election Form before the 90-day period begins, a new Benefit Election Form must be completed. If you complete the Benefit Election Form on or after your intended Benefit Commencement Date, it may be necessary for you to choose a later Benefit Commencement Date; for more information, please contact the Fund Office.

Before you complete the Benefit Election Form, it is important that you understand the various forms of pension payment available to you. The Explanation of Forms of Pension Payment has been prepared to help you become familiar with the forms. The explanation includes information showing the relative financial effect of electing various forms of pension payment.

As you can see from the above, it will be necessary for you to furnish the Fund Office with your completed Pension Application Form and your Benefit Election Form before your Benefit Commencement Date. Because of this, it will ordinarily not be possible for the Fund Office to provide you with actual benefit information prior to completing the forms. If you wish to receive actual benefit information it may delay your Benefit Commencement Date.

Sincerely,

Board of Trustees

Laborers' Trust Funds

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

PART I

PENSION APPLICATION FORM

1. NAME *(Last, First, Middle)*			2. SOCIAL SECURITY NUMBER	3. HOME TELEPHONE # ( )
4. HOME ADDRESS *(Number, Street or Rural Route)*			5. DATE OF BIRTH	6. AGE LAST BIRTHDAY *(attach proof of age & see next page)*
7. CITY, TOWN OR POST OFFICE	STATE	ZIP	8. LOCAL UNION NUMBER	9. TRUST FUND NUMBER
10. DATE YOU RETIRED OR PLAN TO RETIRE *(month, day, year)* / /	11. ARE YOU WORKING AT THE PRESENT TIME? ☐ YES *(Name of present employer)* _____ ☐ NO *(Name of last employer)* _____			
12. TYPE OF PENSION REQUESTING _____				

DISABILITY PENSION

13. ARE YOU APPLYING FOR A DISABILITY PENSION? ☐ YES ☐ NO
(If NO, skip to block 22, if YES, please complete the following):

14. NATURE OF DISABILITY *(Attach medical report from your physician)*	15. DATE DISABILITY OCCURRED 16. DATE ON WHICH YOU CEASED WORKING *(month, day, year)* / /

17. HAVE YOU APPLIED FOR A SOCIAL SECURITY AWARD? ☐ YES ☐ NO

(If YES , attach a copy of award to this application) (If NO, you must also apply to Social Security and receive award before action can be taken)

18. IS THIS DISABILITY COVERED BY THE WORKERS' COMPENSATION LAW? ☐ YES ☐ NO

19. ARE YOU NOW RECEIVING WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO
(If YES, attach a copy of award to this application)

20. DO YOU HAVE A CLAIM PENDING FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO
(If YES, attach a separate sheet of paper with details concerning this claim)

21. HAVE YOU RECEIVED A WORKERS' COMPENSATION LUMP SUM SETTLEMENT? ☐ YES ☐ NO
(If YES, please enter the amount $)

WORK HISTORY

22. WORK HISTORY - PROVIDE DATES AND NAMES OF EMPLOYERS THAT YOU FEEL YOUR PENSION SHOULD BE BASED UPON:

DATES	LOCAL	NAME OF EMPLOYERS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Block 6 After entering your age on your last birthday, arrange to obtain and attach to the application proof of your age. One of the types of proof of age listed below must be furnished. Proof as high in order on the list as possible should be submitted if you have it because such proof is generally more convincing. For instance, if you have or can readily obtain a birth certificate, it should be submitted rather than a baptismal certificate or a statement of birth shown by a church record. If you do not have either of these proofs, or they are not readily obtainable, try to submit the proof listed below in order, rather than the one low on the list. You must attach a photostatic copy of proof of age, except that you are cautioned that NATURALIZATION PAPERS, UNITED STATES PASSPORTS, AND IMMIGRATION PAPERS *may not be photostated.* If any of these is the only proof of age you have, submit the original and it will be returned to you.

1. Birth certificate.

2. Baptismal certificate or a statement as to the date of birth shown by a church record, certified by the custodian of such record.

3. Notification of registration of birth in a public registry of vital statistics.

4. Certification of record of age by the U.S. Census Bureau.

5. Hospital birth record, certified by the custodian of such record.

6. Document showing approval of Social Security pension.

7. A foreign church or government record.

8. A signed statement by the physician or midwife who was in attendance at birth, as to the date of birth shown on their records.

9. Naturalization record (PHOTOSTAT NOT PERMITTED; SUBMIT ORIGINAL).

10. Immigration papers (PHOTOSTAT NOT PERMITTED; SUBMIT ORIGINAL).

11. Military record.

12. Passport (U.S. PASSPORTS MAY NOT BE PHOTOSTATED; SUBMIT ORIGINAL).

13. School record, certified by the custodian of such record.

14. Vaccination record, certified by the custodian of such record.

15. An insurance policy which shows the age or date of birth.

16. Marriage records showing date of birth or age (application for marriage license or church record, certified by the custodian of such record; or marriage certificate).

17. Other evidence such as signed statements from persons who have knowledge of the date of birth, voting records, poll-tax receipts, driver's license, etc.

Laborers' Trust Funds
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(866) 553-6559 - Toll Free

RETIREMENT DECLARATION
PART II

Name of Member_____ Local No._____

Social Security Number_____ Trust Fund No._____

Upon retiring on a pension from the Laborer's District Council Pension and Disability Trust Fund, I declare that I will be bound by the rules and regulations of the Pension Plan as they now exist or be hereafter amended and that:

1. I will withdraw completely from any further employment in the same industry covered by the Plan or in the same trade or craft including any related work as a supervisor, except as otherwise provided in the Plan.

2. I understand that if I enter such employment or activity, retirement benefits shall not be payable for the months of such activity.

3. If I accept employment in work regularly performed by the Union or in any other building trades craft, I will notify the Fund Office in writing within 30 days after I enter into such employment or activity.

4. Unless I have elected the automated direct deposit , I understand that I must personally endorse each check.

5. Date I stopped working or plan to stop work _____.

EXPLANATION OF FORMS OF PENSION PAYMENT

INTRODUCTION

For various personal reasons, you may prefer to take your pension in some other way than you would automatically receive it under the terms of the Plan. If you want your pension paid to you in a different way, you can choose one of the benefits described below. Your choice must be made in writing before your Benefit Commencement Date (for a description of this term, see the first page of the Benefit Election Form). You can cancel or change your choice at any time before your Benefit Commencement Date. If you are married, your spouse must consent to your choice if it is the Single Life Annuity Benefit or the Ten Year Certain Benefit. In addition, you have the right to decide not to begin receiving your pension at anytime prior to the Benefit Commencement Date.

Normal Form - Single Life Annuity Benefit **(36 Payment Guarantee)**

The Plan's basic benefit provides a monthly pension payable to you for the rest of your life or until a total of 36 monthly payments have been made to you and your beneficiary. This is called a 36-Payment Guarantee Benefit. The monthly payments made to you under the 36-Payment Guarantee Benefit would be larger than those made under the Joint and Survivor Benefit. However, after your death no benefit would be payable to any beneficiary, if you have already received 36 monthly payments of your pension.

Ten Year Certain

The 10-year certain annuity option guarantees payment for your lifetime or 10 years, whichever is longer, to you and your beneficiary. If you do not receive 120 payments at the time of your death, your beneficiary will receive the balance of them.

If you are not married on your Benefit Commencement Date, you will automatically receive your pension under the 36-Payment Guarantee Benefit unless you elect otherwise. However, if you are married on your Benefit Commencement Date, your pension will automatically be paid under the 50% Joint and Survivor Benefit unless you reject this form and elect another form of payment with your spouse's consent.

Joint and Survivor Annuity Benefits

This type of pension means you will receive a reduced pension during your lifetime, with a percentage of your pension being continued to your spouse for the rest of his or her lifetime. If your spouse should predecease you (unless you are retiring under a disability pension), your benefit will automatically return to the amount payable under the 36-Payment Guarantee Benefit effective the first of the month following your spouse's death. The new amount will be payable to you for the remainder of your lifetime. You can choose to have 50% or 100% of your reduced pension paid to your spouse after your death. As mentioned above, if you are married, your pension is automatically paid as the 50% Joint and Survivor Benefit, unless you choose another form of payment, with your spouse's consent.

If the Joint and Survivor Benefit applies to you, your 36-Payment Guarantee Benefit will be reduced by a joint and survivor factor. The appropriate factor depends on the percentage of your benefit continued to your beneficiary, i.e., 50%, 75% or 100%; it also depends upon your age and the age of your spouse on your Benefit Commencement Date. The following provides the reduction that may be expected in the 36-Payment Guarantee Benefit under the three Joint and Survivor Benefit percentages.

CALCULATIONS

50% Joint & Survivor Annuity Benefit

90% of the 36-Payment Guarantee Benefit if participant and spouse are both same age.

minus (–) ½% for each year or part thereof participant is older than spouse.

plus (+) ½% for each year or part thereof participant is younger than spouse.

75% Joint & Survivor Annuity Benefit

82.5% of the 36-Payment Guarantee Benefit if participant and spouse are both same age.

minus (–) ½% for each year or part thereof participant is older than spouse.

plus (+) ½% for each year or part thereof participant is younger than spouse.

100% Joint & Survivor Annuity Benefit

75% of the 36-Payment Guarantee Benefit if participant and spouse are both same age.

minus (–) ½% for each year or part thereof participant is older than spouse.

plus (+) ½% for each year or part thereof participant is younger than spouse.

EXAMPLES

Assumptions: 36-Payment Guarantee Benefit = $1,000
Participant Age = 62 years, 1 month
Spouse Age = 59 years, 6 months
Spouse is 3 years or part thereof younger than participant

	50% J&S *$1,000 x 90%* (-1.5% for spouse age difference)	***75% J&S*** *$1,000 x 82.5%* (-1.5% for spouse age difference)	***100% J&S*** *$1,000 x 75%* (-1.5% for spouse age difference)
Monthly Benefit to Participant While Both Participant & Spouse Alive	$885.00	$810.00	$735.00
Monthly Benefit to Spouse if Participant Predeceases Spouse	$443.00	$607.50	$735.00
Monthly Benefit to Participant if Spouse Predeceases Participant (except for Disability Pension) *	$1,000.00	$1,000.00	$1,000.00
Monthly Benefit to Participant on Disability Pension through age 62*	$1,000.00	N/A	N/A
Monthly Benefit to Participant on Disability Pension after age 62*	$885.00	N/A	N/A

* - If you are applying for a Disability Pension and have an eligible spouse, please contact the Fund Office for additional information on benefit options.

Disclosure of Relative Values of Option Payment Forms

IRS regulations require plans such as ours to give retiring participants a comparison of the relative values of the benefit payment options generally available under the plan. The aim is to help you make an informed choice about the form in which you receive your retirement benefits. "Relative value" means the actuarial present value of each optional form of payment relative to the value of the Qualified Joint and Survivor Annuity (QJSA) or, for single people, the plan's normal form of annuity payment. If the relative value of the optional form falls within IRS-prescribed parameters, it may be described as "approximately equal" to the QJSA or normal form. In the boxes next to the names of optional forms on the chart that follows, "AE" stands for "approximately equal."

The following chart shows the relative values of the benefit payment options that our plan makes generally available to retiring participants. As you can see, some of the benefits have approximately the same value (indicated by "AE") for a participant who is the same age as his or her spouse, and some of them do not have approximately the same value. This is also true for disability pensioners. This conclusion is based on the valuation and reporting methodologies described in the IRS regulation, which can be found at Treas. Reg. section 1.417(a)(3)-1. Upon your written request, we will give you a similar comparison based on your own age and estimated benefits, and on any other payment forms for which you are eligible.

As noted, these relative values are based on comparing the actuarial values of the benefit payment options to the actuarial value of the QJSA pension (or the normal-form Single Life Annuity with 36 months guaranteed). Actuarial values of pension benefits are determined using mortality and interest assumptions. Mortality assumptions are based on standardized tables developed by actuarial organizations and life insurance companies, which analyze information about large groups of people to project the rates at which groups of individuals at different ages are expected to die. These statistical mortality projections are used to develop "average life expectancies." The interest assumption is an estimate of the likely investment earnings, over time, on the money put aside to pay the benefits. This is relevant in the determination of actuarial value because investment earnings will provide some of the funds to pay the benefits.

The values were calculated, for comparison purposes, assuming a 7% interest rate and that, on average, participants would live as long as predicted under the 1971 Group Annuity Mortality Table (the 1965 Railroad Retirement Board All Disabled Ultimate Mortality Table, for disability retirees).

It is important that you realize that this chart is not a guarantee or even a prediction of what you will actually receive after you retire. You should not rely on it as if it were. The actual value of a stream of annuity payments for any individual, and its comparison to the values of different payment forms, will vary depending on how long the individual and spouse in fact live and on their ages when payments start. This is not the only information you should take into account when choosing your payment form for retirement. Other factors you might want to take into account in deciding how much a particular payment option is worth to you personally, in comparison to the other forms in which your pension can be paid, include your health, your other sources of retirement income, the resources available to your spouse or family after you die, availability of life insurance, etc. You may want to consult a financial advisor in making this important decision.

To obtain an individual relative values estimate, please send a written request to:

Kisha Grey, Pension Manager
Laborers' District Council Pension and Disability Trust Fund No. 2
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Relative Value Charts for Laborers' District Council Pension and Disability Trust Fund No. 2
Pension and Disability Plan

Non-Disabled Single Participant

Commencement Age	Normal Form Life Annuity with 3 Year Certain	10 Year Certain
45	100%	91%
50	100%	92%
55	100%	93%
60	100%	94%
65	100%	AE

Non-Disabled Married Participant

Commencement Age	Normal Form Life Annuity with 3 Year Certain	QJSA 50% J&S with Pop-up	75% J&S with Pop-up	100% J&S with Pop-up	10 Year Certain
45	AE	100%	94%	89%	AE
50	AE	100%	AE	90%	94%
55	AE	100%	AE	92%	94%
60	AE	100%	AE	94%	93%
65	AE	100%	AE	AE	94%

AE: Approximately equal

Assumptions:

Interest	7.00%
Participant Mortality	1971 Group Annuity Mortality Table for males
Beneficiary Mortality	1971 Group Annuity Mortality Table for males, set back 7 years
Spouse Age	Same age as participant

Relative Value Charts for Laborers' District Council Pension and Disability Trust Fund No. 2
Pension and Disability Plan

Disabled Single Participant

Commencement Age	Normal Form Life Annuity with 3 Year Certain	10 Year Certain
30	100%	AE
35	100%	AE
40	100%	AE
45	100%	AE
50	100%	AE
55	100%	AE
60	100%	107%

Disabled Married Participant

Commencement Age	Normal Form Life Annuity with 3 Year Certain	QJSA 50% J&S with Pop-up	75% J&S with Pop-up	100% J&S with Pop-up	10 Year Certain
30	87%	100%	AE	AE	88%
35	87%	100%	AE	AE	88%
40	87%	100%	AE	AE	88%
45	88%	100%	AE	AE	89%
50	88%	100%	AE	AE	90%
55	88%	100%	AE	AE	91%
60	87%	100%	AE	AE	93%

AE: Approximately equal

Assumptions:

Interest	7.00%
Participant Mortality	1965 Railroad Retirement Board All Disabled Ultimate
Beneficiary Mortality	1971 Group Annuity Mortality Table for males, set back 7 years
Spouse Age	Same age as participant

Laborers' Trust Funds
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500

Benefit Election Form of Payment of Retirement Pension
Part III

Section A - Personal *(To be completed by All Participants)*

Name of Participant _____

Benefit Commencement Date _____ (the first day of the month to coincide with or following the date you satisfy all of the conditions for entitlement to a pension, including termination of covered employment).

Section B - Form of Payment *(To be completed by All Participants)*

☐ Form A - 36-Payment Guarantee Benefit (Single Life Annuity)

☐ Form B - 10-Year Certain Benefit

☐ Form C - 50% Joint and Survivor Benefit

☐ Form D - 75% Joint and Survivor Benefit

☐ Form E - 100% Joint and Survivor Benefit

Section C - Beneficiary Designation *(To be completed by All Participants)*

Name of Beneficiary:

_____

Address: _____

_____

Related to Me As:

_____

Date of Birth of Beneficiary:

_____ (attach proof of age)

Your spouse must consent to the designation of any beneficiary other than your spouse. Your spouse must consent to any change in beneficiary.

Section D - Certification of Marital Status *(To be completed by All Participants)*

I understand that the law provides that if I am married at the time I begin receiving my pension under the Plan, my spouse must be provided a pension for his or her lifetime after I die unless my spouse and I elect to waive the spousal benefit within the 90-day period ending on my Benefit Commencement Date. I understand that this spousal benefit is automatically provided under Form C with my spouse as beneficiary. Also, I understand that I may elect Form C (50% Joint & Survivor Benefit), Form D (75% Joint & Survivor Benefit)or Form E (100% Joint and Survivor Benefit) without my spouse's consent. Finally, I understand that I may revoke my election at any time before my Benefit Commencement Date.

I certify that:

☐ I have never been married.

☐ I am not legally married at this time. In the event I marry on or before my Benefit Commencement Date, I will notify you. (Please provide the Fund Office with a copy of divorce decree, separation agreement, or death certificate if you have ever been married.)

☐ I am unable to locate my spouse. (The Fund Office will contact you to obtain additional information.)

☐ The person signing Section F - Spousal Consent to Waiver of Survivor Benefits is my legal spouse. (Attach marriage certificate.)

Section E- Signature *(To be completed by All Participants)*

I acknowledge that I have completed Section A, Section B, Section C and Section D. If Form A (36 Payment Guarantee) or B (10 Year Certain) of Section B applies, I have also completed Section F.

I hereby certify that the information is true and correct to the best of my knowledge and belief. I understand that a false statement may disqualify me for pension benefits, and that the Trustees shall have the right to recover any payments made to me because of a false statement.

Signature of Member_____ Date_____

Signature of Witness_____ Date_____

(Must be Someone other than Spouse or Beneficiary)

Section F - Spousal Consent to Waiver of Joint and Survivor Benefit with Spouse as Beneficiary *(To be completed by the Spouse of the Participant if Form A (36 Payment Guarantee) or Form B (10 - Year Certain) is elected.*

I, _____, understand that the law requires that I be the recipient of lifetime survivor benefits equal to at least 50% of my spouse's lifetime benefit, unless I consent to my spouse's election to waive such benefit. I also understand that lifetime survivor benefits are provided under Form C (50 % Joint & Survivor Benefit), D (75% Joint & Survivor Benefit) or E (100% Joint & Survivor Benefit); however Form A (36 Payment Guarantee) or Form B (10 Year Certain) has been elected. I consent to the waiver of the lifetime survivor benefit and the election of Form_____. I understand that the effect of the waiver is to cause me to give up my survivor benefit protection. I also consent to the Beneficiary selected under Section C. I certify that I am the legal spouse of the Participant.

_____ _____

_____Signature of Spouse Date

Witness: **Spouse's signature must be witnessed by either a Plan Representative or a Notary Public (Choose either A or B)**

☐ A _____

Name and Title of Plan Representative (Please Print)

_____

Signature of Plan Representative

☐ B State of _____

County of _____

On this _____day of _____, 20_____, I, _____ hereby

certify that _____ personally appeared before me on this day and acknowledged the due execution of the foregoing instrument.

Given under my hand and official seal this _____ day of _____, 20_____.

My commission expires _____.

_____

Notary Public

(SEAL)

Statement of Understanding
(For Spouse of Retiring Member)

I have the option of having this document explained by the Fund Office. I waive my right and will sign before a notary declaring that I understand the following. Please initial all applicable lines.

_____ My spouse did not choose a Joint and Survivor retirement benefit. I **will not** receive life-time survivor pension payments after the retiree's death.

_____ My spouse selected a 36-Month Payment Guarantee Option **or** 10-Year Certain Option. My spouse will receive benefits for the rest of his life and **I will not**.

_____ If the 36-month guarantee benefit was selected – The beneficiary **will not** receive a benefit when my spouse dies if 36 months of pension payments were paid out. *I will only receive a benefit if less than 36 payments were paid to my spouse. My benefit will stop with the 36th payment.*

OR

_____ If the 10-Year Certain option was selected – The beneficiary **will not** receive a benefit when my spouse dies if 10 years of pension payments were paid out. *I will only receive a benefit if the pension was paid for less than 10 years. My benefit will stop after 10 years of payments are paid out.*

_____ I am the legal spouse and agree to the Beneficiary named in Section C of the application, which is_____.

_____ ***I understand that this choice cannot be changed after retirement payments begin.***

_____
Signature of Spouse Date

Witness: **Spouse's signature must be witnessed by a Plan Representative or Notary Public (Choose A or B)**

A)

Print Name & Title of Plan Representative Date

_____
Signature of Plan Representative

B)

State of County of

On this _____day of _____, 20_____, I, _____ hereby certify

that _____ personally appeared before me on this day and

acknowledged the due executive of the foregoing instrument.

Given under my hand and official seal this_____ day of _____, 20_____. **(SEAL)**

My Commission expires: _____ _____
Notary Public

Statement of Understanding for Retiree Electing a Joint & Survivor

Benefit Election with a Pop-Up Feature

If your spouse dies before you, your monthly pension payment will increase (pop-up) to the Straight Life Annuity Benefit (36 Payment Guarantee). This is the amount you would have received if you had not selected a Joint and Survivor benefit.

The retiree must notify the Fund Office with a copy of the death certificate. We will process the adjustment for the increase in the following month.

Note: Once your benefit is increased due to a "Pop-Up", it is final and binding. The benfit will not change if you re-marry.

I have read and understand the statement above.

Retiree Signature	Print Name	Date

AUTHORIZATION FOR AUTOMATIC DEPOSITS (ACH CREDITS)

LABORERS' DISTRICT COUNCIL PENSION AND DISABILITY TRUST FUND NO. 2

SECTION A

I hereby authorize the Laborers' District Council Pension and Disability Trust Fund No. 2, (hereinafter called "Fund") to initiate credit entries to my checking ( ) or savings ( ) account (select one)* indicated below, AND, IF NECESSARY, TO INITIATE A DEBIT OF ANY ERRONEOUS OVERPAYMENTS, for the depository named below (hereinafter called "Depository"), and to credit and/or debit the same to such account.

*** Please attach a voided check if a checking account is selected.**

ACCOUNT HOLDER'S NAME_____

DEPOSITORY (BANK) NAME_____

BRANCH_____

CITY_____ STATE_____ZIP_____

TRANSIT/ABA_____ ACCOUNT #_____

PARTICIPANT'S NAME_____

_____ADDRESS_____

_____PHONE NUMBER_____

SECTION B

If the checking/savings account designated in this Authorization is a joint account, please provide the following information on the non-participant/beneficiary joint account holders.

NAME_____

_____RELATIONSHIP TO PARTICIPANT_____

SSN_____

_____ADDRESS_____

PHONE NUMBER_____

SECTION C

If the status of my account changes from an individual to a joint account, or if there is any change to the status of a joint account holder, I hereby agree to notify the Fund of any such change and to provide the information set forth in Section B above, no later than fifteen (15) calendar days from such change of account status.

This Authorization shall remain in full force and effect until the Fund has received written notification from me of its termination with sufficient time to afford the Fund a reasonable opportunity to act on it.

I HEREBY SWEAR AND AFFIRM, UNDER PENALTY OF PERJURY, THAT THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND THAT I FULLY UNDERSTAND MY OBLIGATIONS AND THE OBLIGATIONS OF MY HEIRS OR ASSIGNS UNDER THIS AUTHORIZATION.

SIGNATURE_____

DATE_____

FOR OFFICE USE ONLY

Date Received_____

Processed by _____

LABORERS' DISTRICT COUNCIL HEALTH AND WELFARE TRUST FUND NO. 2

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(866) 553-6559 – Toll Free

Application for Retired Employee Medical Benefits

Name: _____ Soc. Sec. No.: _____

You can participate in the health plan after retiring if you meet all of these requirements:

- You were eligible for coverage under the Plan at any time within 12 months of the date you retired,
- You have earned at least 10 future service credits under the Laborers' District Council No. 2 Pension Plan, and
- You are not eligible for Medicare. (Most people become eligible for Medicare at age 65.)

If you are eligible at the time you retire, you will have the chance to accept or reject this coverage. You must notify the Fund of your decision within 45 days of retiring. If you meet the requirements of 1) and 2) above, your spouse is eligible for this benefit, provided that he/she is not eligible for Medicare.

The benefits provided are specified under **Schedule 4** in the Summary Plan Description.

IF YOU HAVE MEDICARE (OR ARE ELIGIBLE FOR MEDICARE), YOU ARE NOT ELIGIBLE FOR THIS COVERAGE.

Monthly Contribution

Once you join the Plan as a retiree, you must pay monthly contributions for yourself and for your spouse, if applicable. The contribution amount at the present time is **$82** per month for each covered person (**$164** per month for retiree and spouse). The contribution amount is subject to change at the discretion of the Board of Trustees. The monthly contribution payment, which will be withheld from your pension check, starts on your pension award date or the date your coverage as an active employee terminates, whichever occurs first. You can drop the coverage at anytime by advising the Fund Office in writing.

♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦

Retiree Medical Coverage Election

I certify that I qualify under the conditions described above and elect the coverage I have checked below (check one only).

☐ Coverage for myself only. I am under age 65 am not eligible for Medicare.

☐ Coverage for me and my spouse. We are both under age 65 and not eligible for Medicare. Spouse's date of birth .

☐ Coverage for my spouse only. Spouse is under age 65 and is not eligible for Medicare. Spouse's date of birth .

I understand that retiree medical coverage will be terminated if I work more than 39 hours in any calender month.

Signed _____ Date _____

LABORERS' DISTRICT COUNCIL HEALTH & WELFARE TRUST FUND NO. 2

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Name of Retiree:_____

Name of Fund Office Reviewer: _____ Date of Interview: _____

PRE-RETIREMENT HEALTH CHECKLIST

The Laborers' District Council Health & Welfare Trust Fund No. 2 presently provides retiree medical for both the Retiree and Spouse at a cost of **$82.00** per person, per month. To be eligible for retiree coverage you must meet all of the conditions below:

	Qualified? **Yes** / **No**	
1. I am not eligible for Medicare (most people are eligible for Medicare at age 65) My age at retirement was: _____ I am eligible for Medicare due to Disability? **Yes / No** (circle response)		
2. I was eligible for medical coverage under the Fund at any time within 12 months from the date I retired: **Yes / No** (circle response) My retirement date is/was: _____ My last date of eligibility is/was: _____		
3. I have at least 10 Future Service Credits under the Laborers' District Council Pension & Disability Trust Fund No. 2 or former Laborers' District Council Pension & Disability Trust Fund No. 3 **or a combination of both** My Pension Future Service Credits are: _____		

❒ I am eligible for Retiree medical based on the above. I wish to:

- ❒ Elect coverage for myself and/or my spouse. (Retiree Medical Application and Authorization to Withhold must be completed.)
- ❒ Elect the one-time waiver of coverage. (Opt-Out Form must be completed.)
  I understand that if I (or my spouse) want to obtain Retiree coverage from the Fund in the future, I/we must maintain continuous coverage, without lapse, from another source and provide proof of this continuous coverage to be able to "opt back in" to the Retiree benefits.

❒ I acknowledge that I am not eligible for Retiree medical because the answer to 1, 2, or 3 above is "NO." My spouse (if married) is also not eligible for this coverage.

_____ _____
Retiree Signature Spouse's Signature

_____ _____
Witness (cannot be spouse) Witness (cannot be spouse)

LABORERS' DISTRICT COUNCIL HEALTH AND WELFARE TRUST FUND NO. 2

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(866) 553-6559 – Toll Free

RETIREE MEDICAL COVERAGE SUSPENSION/WAIVER ELECTION

Retiree's Name: _____ SSN: _____

Effective Date of Laborers' District Council Health & Welfare Trust Fund No. 2 coverage: _____

I WISH TO SUSPEND/WAIVE LABORERS' DISTRICT COUNCIL HEALTH & WELFARE TRUST FUND NO. 2 RETIREE MEDICAL COVERAGE FOR:

□ Myself □ My Spouse Effective Date of Suspension: _____

I understand that to qualify for reinstatement of suspended Retiree Medical Coverage in the future, I must:

- Submit a written request for reinstatement to the Fund Office prior to termination of ***other health coverage***.
- Provide evidence that the individual(s) to be reinstated (myself and/or my spouse) have maintained continuous coverage under another health plan for the entire period of the suspension. The evidence can be copies of enrollment forms or identification cards showing the coverage dates, certificates of creditable coverage or other correspondence from the health plan verifying dates of coverage.
- The reinstatement must be the beginning of the month, for example December 1, January 1, etc.

I UNDERSTAND THAT NO BENEFITS WILL BE PAID BY THE LABORERS' DISTRICT COUNCIL HEALTH & WELFARE TRUST FUND NO. 2 FOR MEDICAL SERVICES RECEIVED DURING THE SUSPENSION PERIOD.

Acknowledged and signed: _____ _____
(Retiree) (Date)

Acknowledged and signed: _____ _____
(Spouse) (Date)

Fund Office Use Only:

Reviewed by: _____ _____Accepted _____Not Accepted

Comments: _____

Confirmation copy mailed to Retiree: _____(Date) _____ (Initials)