

PLUMBERS AND STEAMFITTERS LOCAL NO. 452 PENSION TRUST FUND

333 West Vine Street, Suite 500, Lexington, KY 40507

Ph: (859) 226-1700 ■ Fax: (859) 226-1179

APPLICATION FOR RETIREMENT BENEFITS



PERSONAL INFORMATION

Name: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth (Attach proof): \_\_\_\_\_

Name of Last Employer: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Date of Last Employment is (will be): \_\_\_\_\_

Marital Status (Check One):  Single  Married (1)  Divorced (2)  Legally Separated (3)  Widowed (4)

- (1) If married, you must submit a copy of your marriage certificate.
- (2) If you were ever divorced or legally separated you must submit a copy of the complete court document that includes reference to this Pension Plan.
- (3) If you were ever divorced or legally separated, you must submit a full copy of the decree and, if applicable, any Order awarding benefits under this Plan to your former spouse.
- (4) If you are widowed please submit a copy of the Death Certificate.

I HEREBY APPLY FOR THE TYPE OF BENEFIT CHECKED BELOW (CHECK ONE ONLY):

- NORMAL RETIREMENT – 62 Years of Age and Over
- EARLY RETIREMENT – 55 Years of Age and 30 Years of Continuous Service with at least 1,500 hours worked after November 1, 2003 (at a contribution rate of at least \$3.53 per hour).
- EARLY RETIREMENT – 55 Years of Age and 35 Years of Continuous Service
- EARLY RETIREMENT – 58 Years of Age and 5 Years of Continuous Service
- TOTAL DISABILITY BENEFIT – 10 Years of Continuous Service Date of Disablement: \_\_\_\_\_

I HEREBY APPLY FOR BENEFITS TO BE EFFECTIVE: \_\_\_\_\_

IF APPLYING FOR A TOTAL DISABILITY BENEFIT, CHECK ONE OF THE FOLLOWING:

- Social Security Disability (Award Attached)
  - I will apply for Social Security Disability immediately.
  - Applied for but not received Social Security Award.
  - Submitting Two Physician's Statements of Disability
- If applying for a Disability Benefit, and you have not been awarded a Social Security Benefit you must provide two completed Physician's Statements of Disability and medical documentation to support the Physician's Statement, including medical reports, evaluations and other medical records.*

IF TWO COMPLETED PHYSICIAN'S STATEMENT OF DISABILITY ARE NOT INCLUDED WITH THIS APPLICATION CONTACT THE FUND OFFICE AT (859) 252-8337.

HAVE YOU WORKED UNDER THE JURISDICTION OF A LOCAL OTHER THAN 452 WHICH RECIPROCATES WITH LOCAL 452?  YES  NO

IF YES, NAME OF LOCAL: \_\_\_\_\_

LAST DATE WORKED FOR RECIPROCATING LOCAL: \_\_\_\_\_

WERE YOU INVOLUNTARILY TRANSFERRED TO LOCAL 452 BY THE U. A.?  YES  NO

IF YES, INDICATE NAME OF LOCAL \_\_\_\_\_  
AND DATE OF TRANSFER: \_\_\_\_\_

DID YOU SERVE IN THE MILITARY SERVICE:  YES  NO  
If yes, provide detailed documentation of your service.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**NAME YOUR BENEFICIARY** – I hereby designate the following beneficiary to receive any payments due under the Plan after my death, unless and until a new beneficiary is designated by me in writing to the Administrative Office.

Name: \_\_\_\_\_ Relationship (Check One)  Spouse  Other: \_\_\_\_\_  
Relationship

Soc. Sec. No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) \_\_\_\_\_

**WAIVER OF JOINT & SURVIVORSHIP OPTION (Must be Notarized)**

If you wish to elect the Single Life guarantee benefit, you may do so by signing this "Waiver of Joint and Survivorship Option." Your spouse must consent to this waiver. Both signatures must be notarized. It is important that you understand your rights and obligations regarding this Joint and Survivorship form of payment and the alternative forms of payment. Please contact the Fund Office if you have any questions.

**Participant:** As a participant in the Pension Trust Fund, I hereby acknowledge that: (1) I have been informed by the Trust Fund of the terms and conditions of the Joint and Survivorship Option; (2) of my right to make and the effect of making an election to waive the Joint and Survivorship form of benefit; (3) the right of my spouse to consent to any such wavier; and (4) of my right to revoke an election to waive the Joint and Survivorship Option before the date that any benefit is first paid to me.

By my signature below, I hereby waive the Joint and Survivorship form of payment and request that my pension be paid to me in an optional form.

**Participant's Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Spouse:** I am the lawfully married spouse of the participant whose signature appears on this form. By my signature below, I hereby consent to the election by my spouse to waive the Joint and Survivorship Option from the Plumbers and Steamfitters Local No. 452 Pension Trust Fund. I understand: (1) that the effect of my consent will be to forfeit any benefit that I am entitled to receive upon my spouse's death under the Joint and Survivorship Option, were I to survive my spouse; (2) that my spouse's Waiver of the Joint and Survivorship Option is not valid unless I consent to it; (3) that my consent is irrevocable; and (4) as a result of this waiver, my spouse may designate that his pension benefit be paid to him in an optional form.

By my signature below, I hereby waive my right to the Joint and Survivorship form of payment.

**Spouse's Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

\* \* \* \* \*

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. Witness my hand and official seal:

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

(Seal)

My Commission Expires: \_\_\_\_\_

DOCUMENTARY EVIDENCE WAS FOUND TO BE SATISFACTORY.  YES  NO

THEREFORE, THIS BENEFIT WAS:  APPROVED FOR PAYMENT EFFECTIVE: \_\_\_\_\_  
 BENEFIT DENIED

**BOARD OF TRUSTEES OF THE PLUMBERS AND STEAMFITTERS LOCAL NO. 452 PENSION TRUST FUND**

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
BY: \_\_\_\_\_ DATE: \_\_\_\_\_