PLUMBERS AND STEAMFITTERS LOCAL NO. 452 PENSION TRUST FUND
230 Lexington Green Circle, Suite 400, Lexington, KY 40503

Ph: (888) 999-7741 ▪ Fax: (859) 226-1191

Thank you for contacting the Benefit Office for the Plumbers and Steamfitters Local No. 452 Pension Plan concerning the benefits available from the Plan. The Application for Benefits packet must be completed in two parts.

The Fund will use the information requested in the enclosed Application (Part One) to determine your eligibility for retirement and the amount you would receive under each form of benefit option. In addition to completing the enclosed Application, please provide copies of the following documents:

- ☐ Birth certificates for you and your spouse *(if married)*
- ☐ Drivers' license, state identification card or U.S. Passport for you and your spouse
- ☐ Marriage certificate *(if currently married)*
- ☐ Divorce or dissolution judgments *(for any prior marriages)*
- ☐ Qualified domestic relations orders "QDROs" (*if an ex-spouse was awarded a portion of your Pension benefits)*
- ☐ Military discharge papers (*if applicable*)

The Benefit Office will review your Application. If you are eligible for retirement, the Benefit Office will provide you with a second Application (Part Two) which will include amounts you are eligible to receive under each retirement benefit option, and election forms to select your retirement benefit option. Part Two also contains several notices that are required by federal law, including:

- ☐ Notice of your right to delay receipt of benefits
- ☐ Explanation of each option available from the Fund
- ☐ Explanation of the relative value of benefit options available from the Fund
- ☐ Explanation of the separation from employment requirement
- ☐ Notice concerning limits on your work after retirement
- ☐ Notice concerning the time period to make a benefit election
- ☐ Notice concerning the need for your spouse to consent to the retirement election
- ☐ Federal and state tax withholding election forms

Important Notice Concerning the Plumbers and Steamfitters Local No. 452 Health and Welfare Fund – Retirees, spouses, and surviving spouses who are disabled and receiving benefits from Social Security are required to enroll in both Medicare Part A and Part B coverage as soon as they become eligible for the coverage. If you or your spouse become eligible for Medicare Part A and Part B prior to age 65 (due to a disability) you must enroll in both Part A and Part B of Medicare in order to retain your coverage as a retiree through this Fund.

Please understand that the Fund cannot begin to pay any benefit until each portion of your application has been fully completed and returned to the Benefit Office and reviewed and approved by the Board of Trustees.

If you have any questions about the Application, required documentation or benefit options, please feel free to contact the Benefit Office.

Sincerely,

Administrator
Plumbers and Steamfitters Local No. 452 Pension Plan

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APPLICATION FOR RETIREMENT BENEFITS – PART ONE

An application for pension benefits may be filed no earlier than 180 days prior to your requested retirement date. Your retirement benefit must begin no later than April 1st following the date you reach age 73 (age 70 ½, if you reached that age before January 1, 2020, and age 72, if you reached that age before January 1, 2023). The failure to begin receiving a benefit by this date may result in significant tax penalties.

For married participants, payment of your benefit cannot begin until 30 days after you have been provided certain disclosures in this application package. With an appropriate signed waiver signed by your spouse, payment can begin as early as the eighth day after you are provided with the disclosures.

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.

CURRENT SPOUSE INFORMATION (if applicable)

Name: _____ Soc. Sec. No.: _____
Last First Middle

Address: _____
Street City State Zip

Telephone: ( ) Date of Birth (Attach proof): _____

FORMER SPOUSE INFORMATION (if applicable)

Name: _____ Soc. Sec. No.: _____
Last First Middle

Address: _____
Street City State Zip

Telephone: ( ) Date of Birth: _____

Date of Death (if applicable): _____

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

☐ NORMAL RETIREMENT – 62 Years of Age and Over – Age 65 for those who become Participants on or after July 1, 2013.
☐ EARLY RETIREMENT – At least 55 Years of Age
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 F8nd office at (859) 252-8337.

Disability Benefits based on physician statements are paid at 70% for a maximum of twenty-four (24) months.

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.

I certify that the information I have provided on this form is, to the best of my knowledge, true and complete. Before final action is taken on my application, I understand it will be necessary for my eligibility for benefits under this Plan to be verified by the Fund Office.

Participant Signature: _____ **Date Signed:** _____

Spouse Signature: _____ **Date Signed:** _____

End of Part One. The Fund Office will contact you shortly concerning your eligibility for benefits and Part Two of your application.