

# FOX VALLEY & VICINITY LABORERS PENSION FUND

2400 Big Timber Road, Building B, Suite 206

Elgin Illinois 60124

1-847-742-0900

## PENSION APPLICATION

### SECTION I. PARTICIPANT INFORMATION

Please complete Items 1, 2 and 3

#### 1. PARTICIPANT INFORMATION:

Name of Participant: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone:(\_\_\_\_\_) \_\_\_\_\_ Local No.: \_\_\_\_\_

Social Security # \_\_\_\_\_ (←attach copy of card) Date of Birth\*: \_\_\_\_\_

Effective Date of Pension: \_\_\_\_\_ Membership Date: \_\_\_\_\_

Date Last Worked: \_\_\_\_\_ Date Last Worked in the Trade: \_\_\_\_\_

Name of Last Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

*\*(Please submit copy of your birth certificate)*

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

#### 2. BENEFIT TYPE (CHECK ONLY ONE):

- Normal Retirement
- 30 & Out
- Early Retirement (Requires 10 future service credits)
- Vested Benefit
- Disability Benefit (Requires 10 future service credits. Must attach the Physician's Medical Report form and/or Certificate of disability from Social Security Administration.)
- Pro Rata Benefit
- Ten year Certain Benefit (Requires application twelve months prior to commencement date. Proof of health may be required.)

#### 3. SPOUSAL INFORMATION (CHECK ALL THAT APPLY):

- I am married (attach copy of marriage license, spouse's birth certificate & social security card).
- I have never been married.
- I am divorced (attach a copy of the divorce decree).
- I am separated (attach a copy of the decree, if legally separated).
- I am a widow/widower (attach a copy of the spouse's death certificate).
- I am remarried (attach a copy of the divorce decree or copy of the spouse's death certificate).

Spouse's Name: \_\_\_\_\_

Spouse's Address: \_\_\_\_\_

Spouse's Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FOX VALLEY & VICINITY LABORERS PENSION FUND**  
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<b>SECTION II. PARTICIPANT EMPLOYMENT INFORMATION</b> <b>Please complete all answers to Questions 1 through 5</b>
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- 1. Have contributions been remitted into other pension funds on your behalf? If yes, please list the names and addresses of the other funds. (You may qualify for a Pro Rata benefit.)**

Yes                       No (Skip to Question 2.)

Fund Name: \_\_\_\_\_ Address: \_\_\_\_\_

Fund Name: \_\_\_\_\_ Address: \_\_\_\_\_

- 2. Have you worked in Contiguous Non-Covered Service for an employer (worked for a signatory employer in a job not covered under the collective bargaining agreement immediately preceding or after the time you worked for the same employer in covered work)? If yes, please complete the following:**

Yes                       No (Skip to Question 3.)

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ Job Title: \_\_\_\_\_

- 3. Have you missed employment due to military service and as a result not received pension credits? If yes, please list years and attach a copy of your discharge papers.**

Yes                       No (Skip to Question 4.)

Years: \_\_\_\_\_

- 4. Have you been granted a benefit freeze? If yes, please the name of your employer and job title.**

Yes                       No (Skip to Question 5.)

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

- 5. Do you understand that if and when you are awarded a benefit, you cannot work in covered employment in the same industry, trade, craft or geographical area of the Fund for 40 or more hours per month without incurring a suspension of your benefit?**

Yes, I understand.

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<b>SECTION III. JOINT AND SURVIVOR BENEFIT INFORMATION</b> <b>Please complete Item 1 and Item 2 where applicable</b>
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**1. ELECTION OF SURVIVOR BENEFIT (Check Only One)**

**Instructions:** If you elect a Survivor Benefit you must *attach a copy of your marriage certificate and a copy of your spouse's birth certificate*. If you are married and reject the Joint & 50% Automatic Pop Up Option Survivor Benefit, your spouse must sign 1B below to consent to the election of another type of benefit. The consent must be witnessed by a notary public or Plan representative. Once a benefit is paid your election cannot be changed under any circumstances.

- A.  Joint & 50% Survivor Benefit Automatic Pop Up Option (Skip to Section 5)
- Joint & 50% Survivor Benefit
- Joint & 100% Survivor Benefit
- Joint & 100% Survivor Benefit Pop Up Option
- 5 Year Certain and Life Option
- 10 Year Certain and Life Option
- Life Annuity (No Survivor Benefit) (If single, skip to Section 4. If married, complete 1B and 2.)

B. I hereby accept the above election.

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

Witnessed By Plan Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Seal:

**2. REJECTION OF JOINT AND SURVIVOR BENEFIT**

**Instructions:** If you elected not to receive a Survivor Benefit, you and your spouse must sign below. Your spouse is hereby consenting to the fact that benefits will cease upon your death. The consent must be witnessed by a Plan representative or notary public.

- A. I reject a Joint and Survivor form of benefit. I understand that in the event of my death, my spouse will not be entitled to any benefit under the Joint and Survivor option.

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

- B. I understand that by consenting to the rejection of a Joint and Survivor Benefit, my spouse will receive a monthly benefit until death; however upon my spouse's death I will not be entitled to any benefit under the Joint and Survivor option.

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

Witnessed By Plan Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Seal:

**FOX VALLEY & VICINITY LABORERS PENSION FUND**  
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<b>SECTION IV (A) BENEFICIARY DESIGNATION - POST RETIREMENT DEATH BENEFIT</b> <b>Please complete Item 1 and Item 2 where applicable</b> <b>(For Active Participants Only)</b>
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**1. PRIMARY BENEFICIARY DESIGNATION**

**Instructions:** If you name more than one beneficiary, include the percentage of the benefit that each beneficiary should receive. *The percentages must equal 100 percent.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Percentage: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Percentage: \_\_\_\_\_

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

**2. MARRIED AND DESIGNATING A BENEFICIARY OTHER THAN YOUR SPOUSE.**

**Instructions:** If you are married and wish to designate a beneficiary(ies) **other than your spouse**, your spouse must consent, in writing, to such designation and the consent *must be witnessed* by a Plan representative or notary public.

I acknowledge and consent to the above beneficiary(ies) as designated. I also understand that as a result of the above beneficiary(ies) designation, I am not entitled to any benefits, upon my spouse's death, under the Plan. I understand that by my signature I am waiving my right to benefits to which I am otherwise entitled by law.

Spouse's Name: \_\_\_\_\_

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

Witnessed By Plan Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Seal:

**FOX VALLEY & VICINITY LABORERS PENSION FUND**  
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**SECTION IV (B) (cont.) BENEFICIARY DESIGNATION – LUMP SUM DEATH BENEFIT**  
**Please complete Item 3 and Item 4 where applicable**

**3. PRIMARY BENEFICIARY DESIGNATION**

**Instructions:** If you name more than one beneficiary, include the percentage of the benefit that each beneficiary should receive. *The percentages must equal 100 percent.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Percentage: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Percentage: \_\_\_\_\_

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

**4. MARRIED AND DESIGNATING A BENEFICIARY OTHER THAN YOUR SPOUSE.**

**Instructions:** If you are married and wish to designate a beneficiary(ies) **other than your spouse**, your spouse must consent, in writing, to such designation and the consent *must be witnessed* by a Plan representative or notary public.

I acknowledge and consent to the above beneficiary(ies) as designated. I also understand that as a result of the above beneficiary(ies) designation, I am not entitled to any benefits, upon my spouse's death, under the Plan. I understand that by my signature I am waiving my right to benefits to which I am otherwise entitled by law.

Spouse's Name: \_\_\_\_\_

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

Witnessed By Plan Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Seal:

# FOX VALLEY & VICINITY LABORERS PENSION FUND

## SECTION V. DIRECT DEPOSIT AUTHORIZATION (OPTIONAL)

If electing direct deposit please complete Item 1 and have an officer of the bank complete Item 2

### 1. PARTICIPANT AUTHORIZATION

**Instructions:** Please attach a copy of a voided check

I authorize the Administrative Office to deposit my pension benefit check directly into my account as follows:

Bank Name: \_\_\_\_\_  Checking or  Savings

Bank Address: \_\_\_\_\_ Account No.: \_\_\_\_\_

Bank Routing No.: \_\_\_\_\_ Bank Phone No.: \_\_\_\_\_

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

Participant's Social Security Number: \_\_\_\_\_

### 2. BANK AGREEMENT

We have noted the above authorization and agree to refund the Fox Valley & Vicinity Laborers Pension Fund any payments received by this institution to which the payee shall not be entitled by reason of death. We further agree to notify the Fox Valley & Vicinity Laborers Pension Fund of the payee's death as soon as possible.

Signature of Bank Officer: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

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**SECTION VI. WITHHOLDING OF MEDICAL SELF PAYMENTS (OPTIONAL)**  
**If you elect to have medical self-payments withheld please complete Item 1**

**1. AUTHORIZATION TO WITHHOLD Medical self-payments**

**Instructions:** If you meet the qualifications as explained in the Notice to Participants and choose to have your medical self-payments withheld from your pension check please complete the information below.

I am applying for a pension benefit from the Fox Valley & Vicinity Laborers Pension Fund and will be eligible for retiree medical coverage. I voluntarily authorize the Administrative Office to withhold 1/3 of the applicable medical self-payments from my monthly pension benefit check and pay that amount to the Fox Valley Laborers Health & Welfare Fund.

I understand that this authorization shall remain in effect until written notice is received from me by the Fund Office revoking that authorization.

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

Participant's SS# \_\_\_\_\_

FOX VALLEY & VICINITY LABORERS PENSION FUND  
WELFARE WITHHOLDING SCHEDULE

PENSION CHECK	PAYS THIS QUARTER	MONTH COVERED FOR MEDICAL
AUGUST SEPTEMBER OCTOBER	OCTOBER	OCT., NOV., DEC.
NOVEMBER DECEMBER JANUARY	JANUARY	JAN., FEB., MARCH
FEBRUARY MARCH APRIL	APRIL	APRIL, MAY, JUNE
MAY JUNE JULY	JULY	JULY, AUGUST, SEPT.

The Pension Department will withhold 1/3 of the quarterly self payment from each monthly pension check to pay the quarterly self payment which will give you medical coverage for that quarter.

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<b>SECTION VI(A) WITHHOLDING OF MEDICAL SELF PAYMENTS (OPTIONAL)</b> <b>If you elect to have medical self-payments withheld please complete Item 1</b>
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**APPLICATION FOR RETIREE BENEFITS AFTER JULY 1, 2001**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security No. \_\_\_\_\_ Telephone: \_\_\_\_\_

I Elect Coverage

I Do Not Elect Coverage

I hereby make application for the Benefit Program checked below to be effective the first day of the Benefit Quarter next following: the effective date of my pension award, or loss of eligibility under a Welfare Plan (as an active employee), whichever shall last occur.

I understand that should I lose eligibility due to failure to remit timely premium payments, I shall not be permitted to reinstate my coverage.

\_\_\_\_\_ Myself \$ \_\_\_\_\_

\_\_\_\_\_ Spouse: \_\_\_\_\_ \$ \_\_\_\_\_  
Name

\_\_\_\_\_ Dependents: \_\_\_\_\_ \$ \_\_\_\_\_  
Name

Number of Service Credits are \_\_\_\_\_

Total Amount due Monthly \$ \_\_\_\_\_  
(if withheld from Pension Check)

Total Amount due Quarterly \$ \_\_\_\_\_

All quarterly payments must be received in the Administrative Office no later than the day preceding the first day of the Benefit Quarter for which coverage is effective.

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

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**VII. DISABILITY BENEFIT**

**Please have your physician complete Items 1 and 2**

**1. MEDICAL REPORT FOR A DISABILITY BENEFIT**

Patient Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_

A. I examined the patient on (date) \_\_\_\_\_ at (location) \_\_\_\_\_

B. The nature of the disability is \_\_\_\_\_

C. The disability commenced on or about (date) \_\_\_\_\_

D. I consider the probable future duration of the disability to be \_\_\_\_\_

E. Based on my examination and conversation with the patient, it is my opinion that the disability: (Check the appropriate boxes)

Was  Was Not contracted, suffered or incurred while the employee was engaged in a criminal enterprise.

Was  Was Not as a result of chronic alcoholism or addiction to narcotics.

Was  Was Not self-inflicted.

Was  Was Not as a result from an injury, wound or disability incurred while serving in the Armed Forces of the United States or arising out of a state of war or civil unrest.

**2. CERTIFICATION OF DISABILITY**

Under the Pension Plan, "Permanent and Total Disability" means in part, total incapacity because of physical or mental condition so as to be prevented thereby from performing any duties for wage or remuneration.

I hereby certify that: (Please check one and complete as appropriate).

I am of the opinion this applicant is Permanently & Totally disabled.

I am of the opinion this applicant can engage in employment as follows:

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone No: \_\_\_\_\_

**SUPPLEMENTAL LUMP SUM RETIREMENT BENEFIT  
ELECTION FORM**

You are entitled to receive a Supplemental Lump Sum Retirement Benefit under the Fox Valley and Vicinity Laborers Pension Fund. You can delay payment of the Supplemental Lump Sum Retirement Benefit for up to 12 months after your retirement.

Distribution amount: \$ \_\_\_\_\_

\_\_\_ I elect to take my distribution at this time.

\_\_\_ I elect to defer my distribution at this time.

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Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date: \_\_\_\_\_