Laborers' District Council
Benefit Funds

Reply to: 665 North Broad Street, 2nd Floor, Philadeldelphia, Pa 19123

Laborers' District Council
of the Metropolitan Area of
Philadelphia and Vicinity

For Pension and Health and Welfare Fund Services, please call:
Tel: ***1-877-LABOR-77*** *or 215-765-2014*
215-236-6700 *or* ***215-765-4633***
Fax: ***215-765-8329***

Dear Participant:

We are pleased to enclose the Pension/Annuity Application you requested. When your eligibility has been determined we will notify you. If you have any questions or need assistance in filling out the enclosed application, please feel free to contact our Pension Processing department.

Please remember that you MUST:

1. Read each question carefully
2. Print all information
3. Answer all applicable questions
4. Attach additional pages if nessary
5. Sign application
6. Complete and return pages 2 through 8 (Failure to return any of these pages will slow processing of your claimPlease include a phone number where you can be reached.
7. **MAIL COMPLETED APPLICATION AND ALL REQUIRED DOCUMENTS (i.e. marriage license; birth certificate; proof of age) TO THE ABOVE ADDRESS**

FAILURE TO SIGN YOUR APPLICATION OR PROVIDE US WITH THE REQUIRED DOCUMENTS WILL RESULT IN ADDITIONAL DELAYS IN THE PROCESSING OF YOUR APPLICATION TO COMPLETION.(see page 7 "DID YOU")

IMPORTANT

Participants and beneficiaries applying for benefits from the Laborers' District Council Construction Industry Pension Fund are now required to provide a copy of their social security card with their application for benefits. If married, the participant's spouse must also provide a copy of their social security card. This does not apply to the spouse's of beneficiaries.

Your claim will not be processed until we have copies of your social security card and if applicable your spouse's.

To get a replacement card, you will need to:

- **Complete an *Application For A Social Security Card* (Form SS-5);**
- **You can obtain Form SS-5 from our office, from your local Social Security office, online at www.socialsecurity.gov or by calling Social Security at 1-800-772-1213;**
- **MAIL OR TAKE THE COMPLETED FORM TO A LOCAL SOCIAL SECURITY OFFICE. Your local office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may also locate the nearest Social Security office on the Internet at http://www.socialsecurity.gov;**

LABORERS' DISTRICT COUNCIL CONSTRUCTION INDUSTRY PENSION FUND

665 North Broad Street. 2nd Floor • PHILADELPHIA, PA 19123
(215) 765-2014 • FAX (215) 765-8329

APPLICATION FOR PENSION/ANNUITY BENEFITS

SECTION I
All applicants please complete

1. NAME	**2. SOCIAL SECURITY NUMBER**
3. DATE OF BIRTH(please attach proof of your age)	**4. TELEPHONE # WHERE YOU CAN BE REACHED**
5. ADDRESS(Please include city, state and zip)	
6. MAILING ADDRESS(if different from your home address) **CITY** **STATE** **ZIP**	
7. IF POSSIBLE, PLEASE INDICATE ANOTHER TELEPHONE NUMBER WHERE YOU CAN BE REACHED?	

8. WHAT IS YOUR CURRENT MARITAL STATUS?

- ☐ **MARRIED** - ***attach a copy of your marriage license and proof of your spouse's age***
- ☐ **DIVORCED** - ***attach a CERTIFIED copy of your divorce decree***
- ☐ **WIDOWED** - ***attach a copy of your spouse's death certificate***
- ☐ **NEVER MARRIED**
- ☐ **MARRIED BUT CANNOT LOCATE MY SPOUSE**

9. WHAT IS YOUR SPOUSE'S NAME?	**10. SPOUSE'S SOCIAL SECURITY NO.**
11. SPOUSE'S ADDRESS(complete if different from yours)	
12. SPOUSE'S BIRTH DATE	**13. SPOUSE'S TELEPHONE NO.**

PLEASE DESIGNATE YOUR BENEFICIARY

BENEFICIARY'S NAME	**BENEFICIARY'S SOCIAL SECURITY NUMBER**
BENEFICIARY'S ADDRESS(please include city state and zip)	

BENEFICIARY'S TELEPHONE NO.	**RELATIONSHIP**	**BENEFICIARY'S BIRTH DATE**

SECTION II
All applicants please complete

1. HAVE YOU EVER APPLIED FOR BENEFITS FROM THIS FUND? ☐ **YES** ☐ **NO**

IF YES, PLEASE INDICATE THE MONTH AND YEAR YOU MADE APPLICATION AND THE TYPE OF BENEFIT YOU APPLIED FOR _____

2. WHAT TYPE OF PENSION ARE YOU APPLYING FOR? (CHOOSE ONE)

- ☐ **EARLY or EARLY VESTED DEFERRED -** (select if you are under 65)
- ☐ **DISABILITY***
- ☐ **NORMAL or VESTED -** (select if you are 65 or older)
- ☐ **PARTIAL -** (select if you worked in jurisdictions other than those covered by Locals, 57,135, 332, 413 and 420)

** To be eligible for disability pension benefits you must have at least 15 years of service, without incurring a break in service and be receiving disability benefits from the Social Security Administration.*

3. WHY ARE YOU TERMINATING EMPLOYMENT?

- ☐ **DISABILITY**
- ☐ **CHANGE OF PROFESSION**
- ☐ **MOVING OUT OF STATE**
- ☐ **REACHED AGE YOU WISH TO RETIRE**
- ☐ **ACCRUED 30 OR MORE YEARS OF SERVICE**
- ☐ **OTHER** _____

4. ARE YOU CURRENTLY RECEIVING OR ARE YOU ELIGIBLE TO RECEIVE RETIREMENT BENEFITS FROM ANOTHER PENSION PLAN(S)?

☐ **YES** ☐ **NO**

IF YES, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Please give the name of all the Pension Plan(s) that are currently paying you benefits or Pension Plan(s) where you may be eligible to receive benefits in the future.

_____

2. When did your benefits commence or when will you make application for the benefit? _____

3. What type of work did you perform to become eligible for these pension(s).

_____

4. If possible, please give the names of the employer(s) who made contributions into these Pension Plan(s) ***(use reverse side if needed).***

_____

5. Did any of the employer(s) listed above ever make pension contributions on your behalf into the Laborers' District Council Construction Industry Pension Fund?

☐ **YES** ☐ **NO**

If YES, please give the name of the employer(s) and the name of the pension plan(s) where the same employer made contributions to us and to another plan. ***(use reverse side if needed)***

_____

SECTION III
All applicants please complete

1. **ARE YOU STILL WORKING IN CONSTRUCTION?** ☐ YES ☐ NO

IF YES, WHEN DO YOU PLAN TO STOP? _____

IF NO, WHEN WAS THE LAST TIME YOU WORKED? _____

What month do you want your benefits to commence? _____

2. **ARE YOU CURRENTLY OR WERE YOU A MEMBER OF ANY LABORERS' INTERNATIONAL LOCAL UNION?**

☐ YES ☐ NO

IF YES, GIVE YOUR LOCAL AND MEMBERSHIP NUMBER:

I AM CURRENTLY OR WAS A MEMBER OF LOCAL UNION #: _____

MY MEMBERSHIP NUMBER IS OR WAS: _____

3. **HAVE YOU EVER TRANSFERRED YOUR MEMBERSHIP TO ANOTHER LABORERS' INTERNATIONAL LOCAL UNION?**

☐ YES ☐ NO

IF YES, PLEASE GIVE US THE LOCAL NUMBER AND THE DATES THAT YOU WORKED AND/OR PAID DUES IN THAT JURISDICTION:

Local Number	Date Transferred In	Date Transferred Out
Local Number	Date Transferred In	Date Transferred Out
Local Number	Date Transferred In	Date Transferred Out

4. **HAVE YOU EVER PERFORMED LABORERS' WORKED OUTSIDE THE FIVE COUNTY AREA?**
(The five county area consists of Philadelphia County, Montgomery County, Chester County, Bucks County and Delaware County)

☐ YES ☐ NO

If yes, please indicate the following (use additional sheets if necessary)

Job Location	Local Union in that Jurisdiction	Date you started work?	Date you stopped work?	Where were your benefits paid?	If known, how much pension service do you have in this jurisdiction?

SECTION IV
Compete if you are applying for credit for non-working periods

1. **HAVE YOU EVER SERVED IN THE ARMED SERVICES OF THE UNITED STATES OF AMERICA?**

☐ **YES** ☐ **NO**

(IF YES, PLEASE ATTACH A COPY OF EVIDENCE OF SEPARATION FROM THE ARMED FORCES)

2. **HAVE YOU EVER RECEIVED WEEKLY SICK BENEFITS FROM EITHER THE BUILDING OR HEAVY HEALTH AND WELFARE FUND?**

☐ **YES** ☐ **NO**

IF YES, ATTACH PROOF INDICATING THE NAME OF THE CONTRACTOR AND THE SPECIFIC DATES YOU RECEIVED BENEFITS. (see page 9)

3. **HAVE YOU EVER RECEIVED WORKMEN'S COMPENSATION? (This means any monies you have been paid for an INJURY you received while working on the Job.) THIS DOES NOT INCLUDE UNEMPLOYMENT COMPENSATION.**

☐ **YES** ☐ **NO**

IF YES, PLEASE ATTACH PROOF INDICATING THE NAME OF THE CONTRACTOR AND THE SPECIFIC DATES YOU RECEIVED BENEFITS. (see page 9)

SECTION V
Complete if you are applying for a disability pension

1. **WHAT IS THE CAUSE OF YOUR DISABILITY?** _____

2. **WHAT IS THE DATE YOUR DISABILITY STARTED?** _____

3. **WHAT IS THE DATE YOU STOPPED WORKING DUE TO YOUR DISABILITY?** _____

ALL APPLICANTS FOR DISABILITY PENSION BENEFITS MUST COMPLETE THE ENCLOSED DISABILITY APPLICATION

SECTION VI All APPLICANTS, IF POSSIBLE LIST ALL YOUR PAST EMPLOYERS (use the reverse side if additional space is needed)			
Name of Employer	**FROM(Month\Year)**	**TO (Month\Year)**	**TYPE OF WORK PERFORMED**

DISABILITY APPLICATION

(ALL DISABILITY APPICANTS MUST COMPLETE, SIGN AND RETURN)

SECTION ONE

Please advise the Fund Office as follows: (check one)

☐ I have been approved for Disability Benefits from the Social Security Administration *(please attach a copy of your award certificate and sign below)*

☐ I have applied for disability benefits from the Social Security Administration *(please complete SECTION TWO and sign)*

☐ I intend to apply for disability benefits from the Social Security Administration *(please complete SECTION TWO and sign)*

☐ I have been denied Disability Benefits from the Social Security Administration *(please complete SECTION TWO and sign)*

☐ I DO NOT intend to apply for Disability Benefits from the Social Security Administration *(please complete SECTION TWO and sign)*

SECTION TWO

DO NOT COMPLETE THIS SECTION, IF YOU HAVE BEEN APPROVED FOR DISABILITY BENEFITS FROM THE SOCIAL SECURTY ADMINISTRATION

1. Please indicate the date you applied or are planning to apply for disability benefits from the Social Security Administration _____.

2. If you have applied for disability benefits from the Social Security Administration and been denied, did you appeal the decision or do you intend to appeal the decision?
   ☐ YES ☐ NO

3. If eligible, do you wish to have early retirement benefits paid to you while you await your determination from the Social Security Administration?
   ☐ YES ☐ NO

4. If possible, please indicate the month and year that you will begin receiving disability benefits from the Social Security Administration, if favorably determined. ***(you may need to get this information from the Social Security Office)*** _____

I understand that in order to be eligible for disability pension benefits, I am required to show proof that I have been awarded disability benefits from the Social Security Administration. In addition, I must also meet the credited service requirements as defined in the Plan of Benefits as it relates to disability pension benefits.

I also understand that that upon my making application for pension benefits, if I have not yet been awarded disability benefits from the social security administration, the fund will make a determination as to my eligibility for early retirement benefits. If I am eligible for early retirement benefits as defined in the Plan of Benefits, I may elect to receive early retirement benefits while I await my determination from the Social Security Administration. Should I be eligible and elect to receive early retirement benefits and subsequently receive a favorable determination from the Social Security Administration, I understand that any lump sum benefits due me as the result of my conversion to a disability pension will be offset by the early retirement benefits that I received.

_____ _____

Participant's Signature Date

DID YOU

- **SIGN AND DATE YOUR APPLICATION?(see below)**
- **INCLUDE PROOF OF YOUR AGE?**
- **INCLUDE PROOF OF YOUR SPOUSE'S AGE?**
- **GIVE US YOUR BENEFICIARY'S CORRECT BIRTH DATE, ADDRESS, TELEPHONE NUMBER AND SOCIAL SECURITY NUMBER?**
- **INCLUDE A PHONE NUMBER WHERE YOU CAN BE REACHED**
- **HAVE ATTACHED THE FOLLOWING DOCUMENTS THAT ARE <u>APPLICABLE</u> TO YOU?**

1. **DON'T FORGET TO RETURN YOUR SIGN AND RETURN YOUR VESTING AND DETAILED WORK SUMMARY REPORT**
2. **YOUR MARRIAGE LICENSE**
3. **A DIVORCE DECREE, IF YOU ARE DIVORCED – YOU MUST INCLUDE**
4. **A DEATH CERTIFICATE IF YOUR SPOUSE IS DECEASED**
5. **YOUR SOCIAL SECURITY DISABILITY AWARD CERTIFICATE, IF YOU ARE APPLYING FOR DISABILITY BENEFITS**
6. **PROOF OF SEPARATION FROM THE ARMED FORCES**

<u>I HEREBY APPLY FOR A PENSION FROM THE LABORERS' DISTRICT COUNCIL CONSTRUCTION INDUSTRY PENSION FUND OF PHILADELPHIA AND VICINITY.</u>

<u>I agree to furnish any information that the Board of Trustees may require for the determination of my eligibility for Pension Benefits at this time and at any other time in order to maintain my eligibility for Pension Benefits.</u>

_____ _____

Signature of Witness **Signature of Applicant**

_____ _____

Address of Witness **Date Signed**

PROOF OF AGE

Every applicant is required to submit proof of age. For this purpose one or more of the following documents may serve as acceptable proof. Because some of these documents are better proof than others, the list is arranged so that the best type of proof is listed first, the next best is second and so on.

1. A birth certificate
2. A baptismal certificate, or a church record which shows the date of birth and is certified by the custodian of such records.
3. Notification of registration of birth in a public registry of vital statistics
4. Hospital birth record, certified by the custodian of such records
5. Birth record of a foreign church or government
6. A signed statement by the physician or midwife who was in attendance at birth, showing the date of birth as it is taken from their records
7. Naturalization records
8. Immigration papers
9. Military record
10. Passport
11. School record, certified by the custodian of such records
12. Vaccination record, certified by the custodian of such record
13. An insurance policy (in force for at least 15 years) which shows age or date of birth
14. Marriage records showing date of birth or age (e.g. application for marriage license or church record) certified by the custodian of such records; or marriage certificate
15. Other evidence, such as signed statements from persons who have knowledge of the date of birth, voting records, poll tax receipts, etc.

WORKMEN'S COMPENSATION

Every applicant applying for pensions credits as a result of receiving Workmen's Compensation must provide written proof that indicates the following:

1. the contractor you were working for when you sustained the injury
2. the date the you started and stopped receiving Workmen's Compensation Benefits

If you do not have this information, the Fund office has forms that you can mail or take to one of the following sources:

1. The Insurance Company that paid your claim - (this is the best and quickest way to get the information)
2. The Workmen's Compensation Bureau, their address and phone number is

   Department of Labor and Industry
   Bureau of Workers Compensation
   1171 South Cameron Street, Room 103
   Harrisburg, Pa 17104-2501
   (Phone 800-482-2383 or 717-772-3742)

3. The contractor you worked for when you sustained the injury

WEEKLY DISABILITY BENEFITS

Every applicant applying for pensions credits as a result of receiving weekly disability benefits from a health and Welfare fund must submit written proof that indicates the following:

1. the name of the Health and Welfare Fund you received weekly disability benefits from
2. the date the you started and stopped receiving benefits

LABORERS' DISTRICT COUNCIL HEAVY AND HIGHWAY AND/OR BUILDING AND CONSTRUCTION HEALTH AND WELFARE FUND
AUTHORIZATION FOR RELEASE OF INFORMATION

= Must be completed

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations. (Neither the plan nor Laborers' District Council receive financial or in-kind compensation in exchange for using or disclosing the health information described below.)

Participant name:_____ **SS Number:**_____

Date of Birth:_____

Persons/organizations providing the information:
Laborers' District Council Heavy and Highway Construction and/or Laborers' District Council Building and Construction Health and Welfare Fund

Persons/organizations receiving the information
Laborers' District Council Construction Industry Pension Fund

Specific description of information (including date(s)): ***Dependent and Beneficiary Census Information***

What is the purpose of the use or disclosure?: ***To help determine/verify the marital status of participant named above. The information will only be used to process a claim for pension and/or annuity.***

(**Note**: "at the request of the individual" is a sufficient description of the purpose of the use or disclosure when the participant initiates the authorization and elects not to provide a statement of the purpose.)

Section B: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the plan conditioning the provision of healthcare except that refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the plan declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. I understand that I get a copy of this form after I sign it. **I understand that this authorization will expire on the date I am no longer covered under the plan.** I understand that I may revoke this authorization at any time by notifying the plan administrator in writing. The revocation will only be effective from the date it is received and logged by the plan administrator and will not apply retroactively.

Participant initials: _____

_____ _____
Signature of participant or participant's representative **Date**
(Pertinent sections of the Form MUST be completed before signing.)

Printed name of participant's representative:_____

Relationship to the participant:_____
(PLEASE INCLUDE EVIDENCE OF AUTHORITY TO SIGN ON BEHALF OF THE PARTICIPANT)

= Must be completed

LABORERS' DISTRICT COUNCIL CONSTRUCTION INDUSTRY PENSION FUND
665 North Broad Street, 2ND FLOOR • PHILADELPHIA, PA 19123
215-765-2014 • FAX 215-765-8329

Direct Electronic Deposit Authorization

Print clearly in black or blue ink

ELECTION: - **PLEASE CHOOSE ONE**- You must sign and date this form to make any change

☐ New Pension Direct Deposit

THIS PORTION TO BE COMPLETED BY PENSIONER:

Full Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ZIP_____

Home Telephone # _____ Cell Phone # _____

Fill out this section start or change your direct deposit. ***If you are canceling your direct deposit, leave this section blank.***	**Financial Institution Stamp**
Type of Account: ☐ Savings ☐ Checking Effective Date: _____	
Name of Institution:_____	
Address of Institution: _____	
City: _____State: _____ Zip Code:_____ Phone # _____	
Routing # (9 digits): _____Account #: _____	
Financial Institution Authorizing Signature **X**_____	

Note: *Checking accounts require a voided check with the account holder's name pre-printed on the check, or a stamp from the financial institution on this form, or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.*

Savings accounts require a stamp from the financial institution on this form or a signed letter from the financial institution on company letterhead confirming the account holder, routing number and account number.

I hereby authorize the Laborers' District Council Construction Industry Pension Fund to (a) deposit my pension amount in my account, chosen above, and (b) to make adjustments and have my account charged for any erroneous credits or other amounts to which I am not entitled. I further understand that should I choose or change this account I must give a new completed form to the Pension Fund at least one month before the pension direct deposit is to be terminated.

I agree that receipt by the above bank or financial institution of my benefit payments from the Pension Fund shall be treated as receipt by me and that neither the Pension Fund, its trustees or its employees shall be responsible or liable in any way for any error or mishandling of the benefit payments by the bank or financial institution named above.

This authorization shall remain in effect until cancelled by me in writing and received by the Pension Fund.

Pensioner's Signature **X**_____ Date_____

**** Original signature required to complete your request. Please Notarize ****

*****FOR OFFICE USE ONLY*****

Change by: _____ Processed by and date: _____ Prenote date: _____ DD date: _____