United Food and Commercial Workers
Unions and Employers Midwest Pension Fund

18861 90th Ave, Suite A ♦ Mokena, IL 60448 ♦ 800-621-5133 ♦ FAX 847-384-0188 ♦ www.ufcwmidwest.org

Application for Pension

First Name	Middle Name	Last Name
Mailing Address		
City, State, ZIP Code		Area Code/Phone
Social Security Number	Date of Birth	Date Last Worked in Covered Employment

Normal or Early Retirement

I am retiring on or after my 55th birthday, without disability. I understand that my pension will be reduced if payments begin before my Normal Retirement Age, as described in my Pension Plan Booklet or in the Plan Document. I request my pension payments to begin:

☐ The First day of _____ _____
month year

Disability Retirement

I am retiring at any age due to permanent disability. I have filed an application for Disability Insurance Benefits under the Federal Social Security Act and (check one):

☐ Attached is a certificate of Social Insurance Award, indicating approval of my application for the Disability Insurance Benefit.

☐ Attached is a disallowance letter from the Social Security Administration which I

☐ do ☐ do not intend to appeal. (If you do not intend to appeal, please attach an explanation of why you are not appealing.)

☐ My case is still under consideration; as soon as I receive my certificate of award or disallowance letter, I will forward a copy to the Pension Office.

Continued on Reverse ... Signature Required on Reverse

Signature Area

In declaring my intent to retire, I fully understand and acknowledge that:

(1) If I am married, any pension payable to me will be paid in the form of a 50% Joint and Survivor Pension, unless both my spouse and I choose otherwise on a Benefit Alternatives Acknowledgement or Election form. A 50% Joint and Survivor Pension means that I will receive a reduced pension for life; after my death, my surviving eligible spouse will receive 50% of that amount for life.

(2) I must immediately notify the Pension Office in writing if I return to work, since my pension may be suspended during any such period of Industry or Covered Employment.

(3) If I am receiving a Disability Retirement pension, I may be required to submit to periodic medical examinations. In the event that I am no longer totally disabled I will immediately notify the Pension Office in writing.

_____ _____

Date Signed Signature, (in ink)

United Food and Commercial Workers
Unions and Employers Midwest Pension Fund

18861 90th Ave, Suite A ♦ Mokena, IL 60448 ♦ 800-621-5133 ♦ FAX 847-384-0188 ♦ www.ufcwmidwest.org

Member Data Sheet

Please print in ink the information requested on this data sheet (front and back). Be certain that you sign and date the form in ink at the bottom of this page.

Last Name, First Name, Middle Name | Social Security Number

Previous Names (such as maiden name), if any | Sex ☐ Male ☐ Female

Place of Birth-City and State or Country | Date of Birth-Month/Day/Year | **Remember to Enclose Your Proof of Age**

Current Address-Full Street Address {post office box number alone is not acceptable) | Area Code/Phone Number

City | State | ZIP Code

Future Address, if known | **DATE ADDRESS WILL CHANGE**

City | State | ZIP code

Are you currently married? ☐ Yes ☐ No | Marriage Date--Month/Day/Year

Spouse's Name | Spouse's Social Security Number | Spouse's Date of Birth-Mo/Day/Year

Are you currently employed?

☐ Yes - May we contact your employer for verification of your employment record? ☐ Yes ☐ No

If we cannot contact your employer at this time, please indicate the date when we may do so {month/day/year)

☐ No - What was your last day worked in a position covered under a UFCW Collective Bargaining Agreement? {month/day/year)

Current employer's name and address | Your position

Number of hrs. you work per month

If you are currently receiving or expect to be eligible for a pension from any other organization, indicate name and address of the other organization:

I certify that the information contained on this Member Data Sheet is true and accurate to the best of my knowledge.

Date | Signature

COMPLETE REVERSE SIDE

Employment History-This section must be fully completed

List all of your periods of employment that you believe will be considered in determining your pension. Such employment may include employment with employers who make or made contributions into the Fund or who were organized by the United Food and Commercial Workers Union. Do not list periods of self-employment (where you were the owner or proprietor). If your employment was not continuous, complete the "reason for Non-Continuous Employment" section below. If you are disabled, complete the "Disability" section below.

Name of Employer {List Most Recent First)	Street Address, City and State	Job Title or Department	Dates of Employment				Average Hours Per Week	Local Union
			From Month|Year		Thru Month|Year			

Reason for Non-Continuous Employment

Give the reason and dates for period during which you are not actively working. For example, periods where you were off work due to illness, injury, pregnancy; (2) working outside the industry; (3) off work for military service (attach a copy of your military record);· (4) working outside local union area; or (5) not working for any other reason (specify reason).

Reason	From Month|Year		Thru Month|Year	

Reason	From Month|Year		Thru Month|Year	

Disability: Complete this section ONLY if you are disabled

Have you applied for Social Security Disability Benefits? ☐ Yes ☐ No If yes, were Benefits ☐ granted or ☐ denied? (Attach copy of Award or Denial letter)
Nature of your disability_____ Date Disability began_____

Date of last examination_____ Doctor's Name and Address _____
Have you worked at all at any occupation since you have become disabled? ☐ Yes ☐ No If yes, complete the chart below

From	Thru	Employer	Monthly Earnings	Kind of Work

United Food and Commercial Workers
Unions and Employers Midwest Pension Fund

18861 90th Ave, Suite A ♦ Mokena, IL 60448 ♦ 800-621-5133 ♦ FAX 847-384-0188 ♦ www.ufcwmidwest.org

Request for Commencement of a Temporary Estimated Pension

The Pension Office has received your request for commencement of your monthly pension benefit and is in the process of obtaining information concerning your career in the Industry. The gathering of information about your employment history is time consuming: In addition to the information that you provide and material submitted from your employers and local unions, a transcript of your employment record from the Social Security Administration is needed.

Because of the length of time necessary to carefully and accurately calculate and process your application for pension benefits, it appears that there will be a substantial delay before you will begin to receive your monthly pension checks. While we pride ourselves in the thoroughness and personal attention given to each pension application, we realize the financial hardships that can be encountered when a pension benefit is delayed.

To help reduce any financial burden the delay could cause, the Board of Trustees has authorized temporary payment of estimated monthly pension benefits during the time required to calculate and process actual pension benefits. In order to take advantage of this temporary estimated payment program, simply complete this form and return it to the Pension Office.

If you decide to begin receiving an estimated monthly pension benefit, the amount of your estimated pension will probably not be the same as your fully calculated pension award. The amount of the temporary benefit will be determined on the basis of readily available information. In most cases, the temporary benefit will underestimate your actual pension benefit.

When your actual benefit amount is determined, and if you were underpaid during the time temporary benefits were paid, you will receive the entire underpayment amount. If, however, you were overpaid during the time temporary benefits were paid, then your permanent pension benefit will be reduced so that over time the overpayment will be repaid-but you will not have to make a lump sum reimbursement.

If you wish to receive a temporary estimated pension benefit, complete and sign the authorization on the reverse side of this form. If temporary benefits are requested, they will begin as soon as possible after this signed authorization is received.

Please contact the Pension Office if you have any questions.

Continued on Reverse

Authorization for Temporary Estimated Pension

First Name	Middle Name	Last Name
Home Address (give street address-post office box number is not acceptable)		
City, State, ZIP Code		Area Code/Phone
Mailing Address if different from above		
Member Social Security Number		Date Last Worked in Covered Employment

I have read the above description and agree to receive a temporary estimated monthly pension benefit until my pension application is fully processed and approved by the Board of Trustees. I understand that the amount of the temporary estimated pension benefit will not likely be the amount of my actual pension benefit. I also understand that once my actual pension benefit amount has been calculated under the Pension Plan provisions, an adjustment to my temporary benefit amount will be made as follows:

if the temporary pension benefit underestimated my actual pension amount, I or my estate will receive the difference between the underestimated temporary amount and my actual pension award; or

if the temporary pension benefit amount overstated my actual pension benefit, I agree to repay the Pension Fund through the reduction of my actual monthly pension benefit. If I die before my actual pension award is known, I authorize my estate to refund any overpayment amount to the Pension Fund.

I am not now, nor have I, nor do I plan to, during those months for which I am now applying for temporary pension payment, work at or in the type of business of the industry covered by the Pension Plan nor am I doing the same kind of work I did prior to this application.

Date Signed

Signature, in ink

United Food and Commercial Workers
Unions and Employers Midwest Pension Fund

18861 90th Ave, Suite A ♦ Mokena, IL 60448 ♦ 800-621-5133 ♦ FAX 847-384-0188 ♦ www.ufcwmidwest.org

Introduction to Benefit Alternatives

This Introduction and the attached "Benefit Alternatives Acknowledgement" explain the various ways that your pension can be paid under the Plan. The Benefit Alternatives Acknowledgement form provides you with an opportunity to request an estimate of your pension under each of the various pension benefit alternatives.

The information that will be provided if you request estimates of your pension will enable you to compare the amount of your pension with and without the various alternatives and will help you decide which form of payment is best for you. The choice of alternate forms of pension payment is an important family decision. Therefore, if you elect the Single-Life Pension, Federal law requires that your spouse must also sign the Benefit Alternatives Acknowledgement. If you do not have a spouse, please indicate that you are not married or are widowed.

Survivor Protection-for pension payments to continue after your death

The forms of pension payment that provide for the automatic continuation of pension payments to your eligible spouse after your death are called the "50% Joint and Survivor Pension" the "75% Joint and Survivor Pension" and the "100% Joint and Survivor Pension". Your spouse is an "eligible spouse" qualified to become the survivor beneficiary of the Joint and Survivor Pension if you are married on the date your pension commences. The "100% Joint and Survivor Pension" is available to you only if you left Covered Employment after your 54th birthday.

Under these alternatives, your pension is reduced during your lifetime because of the continuation of pension payments after your death. The amount of the reduction will depend on which alternative you elect and on your age and the age of your spouse at the time you retire. The table on the following page shows the approximate percentage of your Single-Life Pension that you would receive with the 50% Joint and Survivor Pension in effect.

The 50% Joint and Survivor Pension is the standard form of pension payment. Your pension will be paid as a 50% Joint and Survivor Pension unless you elect otherwise in writing before your pension begins. Under the 50% Joint and Survivor Pension:

- during your lifetime, you would receive a reduced pension, and
- after your death, your surviving eligible spouse would receive 50% of your reduced pension for life.

The 75% Joint and Survivor Pension is similar to the 50% Joint and Survivor Pension except that your pension is reduced by a higher percentage in order to provide a greater benefit for your spouse:

- during your lifetime, you would receive a reduced pension, and
- after your death, your surviving eligible spouse would receive 75% of your reduced pension for life.

The 100% Joint and Survivor Pension is similar to the 75% Joint and Survivor Pension except that your pension is reduced by a higher percentage in order to provide a greater benefit for your spouse:

- during your lifetime, you would receive a reduced pension, and
- after your death, your surviving eligible spouse would receive 100% of your reduced pension for life.

If you want more information concerning the Survivor Protection forms of pension payment available to you, check the "Request for Estimates of Joint and Survivor Alternatives" box on the Benefit Alternatives Acknowledgment form.

If you do not wish to provide pension payments after your death, you must waive the Joint and Survivor Pension and elect a Single-Life Pension-a pension payable only to you, with payments permanently stopping at the time of your death. Check the "Request for Single-Life Pension" box on the Benefit Alternatives Acknowledgement form. If you are married, your spouse must also sign the Acknowledgement form and both signatures must be notarized by a notary public or personally witnessed by a Trustees' Representative at the Pension Office.

Benefit Election Period

The Pension Plan provides for an Election Period during which you may elect, revoke or change any election. The Election Period expires on the later of the date that your pension begins (or your Normal Retirement Date, if receiving a Disability Pension) or on the 91st day following the date that estimated pension amounts are provided to you by the Pension Office. If your pension payments begin before the Election Period expires, you may only change your election to either the Single-Life Pension or the 50% Joint and Survivor Pension. Once the Election Period has expired, the election cannot be changed or canceled. A Pension Application must be formally filed before any pension can begin. A request for estimated pension amounts does not commit you to any election at this time.

Joint and Survivor Pension Example

You are retiring at age 62 with a monthly Single-Life Pension amount of $300 and wish to provide the 50% Joint and Survivor Pension for your spouse, age 62. Your monthly pension would be $274.44 ($300 x 91.48%) during your lifetime. After your death, your spouse would receive $137.22 (50% x $274.44) for life.

Percentage of Single-Life Pension Payable with the 50% Joint and Survivor Pension Effective

	Your Age When Pension Benefits Begin			
Your Spouse's Age	**55**	**57**	**60**	**62**
53	93.08%	91.86%	89.68%	87.98%
55	93.61%	92.45%	90.37%	88.72%
57	94.14%	93.05%	91.07%	89.49%
60	94.92%	93.94%	92.13%	90.68%
62	95.43%	94.53%	92.84%	91.48%
65	96.16%	95.37%	93.89%	92.67%

This table takes into consideration only the reduction for the 50% Joint and Survivor Pension. Any early retirement reduction is in addition to the reductions shown on the table.

Questions?

If you have any questions or need assistance, please contact the Pension Office toll-free at 800-621-5133

Benefit Alternatives Acknowledgement

Refer to the "Introduction to Benefit Alternatives" before completing this form.
Complete only if you are over or near age 55 (the earliest benefits can begin). Please use ink.

Check one box only

Joint and Survivor Alternative -

☐ Request for Estimate of Joint and Survivor Alternatives: I request an estimate of my pension payable under all available benefit alternatives, as well as an estimate of my pension payable if I waive the alternatives. I understand that I will be given the opportunity to waive or elect any of the alternatives after I receive this information.

Spouse's Printed Name (last, first, middle)	
Spouse Birthdate (month, day, year)	Spouse Social Security Number

or

Single-Life Pension - **spouse signature/notarization required only if married and electing Single-Life Pension**

☐ Request for Single-Life Pension: I hereby waive my right to have pension benefits continue after my death. I want to receive all pension benefits myself. I understand that all pension payments will cease upon my death and that I cannot change this benefit election after my Election Period has expired.

I understand that completion of this Benefit Alternatives Acknowledgement form does not necessarily indicate eligibility for pension benefits. I further understand that requesting an estimate does not commit me to any election.

Date_____ Employee Signature_____

Employee Soc Sec# _ _ _ _ _ _ _ _ _ _ _ Employee Printed Name _

☐ Not Married ☐ Widowed Spouse Signature _

If you are married and you marked the box "Request for Single-Life Pension" above, your spouse must also sign and both signatures **must be notarized** by a notary public or personally witnessed by a TrusteesRepresentative at the Pension Office.

State of_____ County of_____

This is to certify that_____and_____both personally known to me to be the persons whose names are subscribed to the foregoing Pension Benefit Alternatives Acknowledgement appeared before me, _____a notary public, this _____day of _____, 20____, and expressly acknowledged to me the execution of said foregoing Pension Benefit Alternatives Acknowledgement as their free and voluntary act, and that they understood the foregoing Pension Benefit Alternatives Acknowledgement and intended to be legally bound by the same.

Signature:_____ My Commission &Seal Expire on_____
Notary Public or Trustee' Representative (**circle one**)

United Food and Commercial Workers Unions and Employers Midwest Pension Fund

18861 90th Ave, Suite A ♦ Mokena, IL 60448 ♦ 800-621-5133 ♦ FAX 847-384-0188 ♦ www.ufcwmidwest.org

Authorization for Release of Health Benefits Information to the Pension Fund

In the course of processing your pension request, the Pension Office may need to contact the Health Benefits Fund to verify hours for which contributions were paid on your behalf and/or periods when you were not working due to disability. This is done to ensure that you receive all credit available to you. Federal law now requires that every adult person must give a written authorization before the Health Benefits Fund may disclose information about your benefits to another person. If an authorization is not on file, the Health Benefits Fund cannot disclose information to the Pension Fund.

Please complete and return this form to us so that the Health Benefits Fund is authorized to disclose to the Pension Fund information regarding your health benefits coverage.

Employee-Member Information

FULL NAME (EMPLOYEE-MEMBER)	SOCIAL SECURITY NUMBER	DAYTIME AREA CODE/PHONE NUMBER
STREET AODRESS	CITY	STATE ZIP

By signing below, I have authorized the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan to disclose my health benefits information as described in this Authorization. I have had an opportunity to review and understand the contents of this entire form and I am confirming that it accurately reflects my wishes:

I am the Employee-Member and I authorize you to disclose information to the United Food and Commercial Workers Unions and Employers Midwest Pension Fund.

Signature _____ Date Signed _____

Description of Information to be Disclosed by the Plan. I understand that the information that may be disclosed by the Plan will include all information created by or received by the Plan related to my eligibility for health benefits and/or payment of health benefits by the Plan.

Expiration of Authorization. This authorization will expire (1) upon the completed processing of my pension request; or (2) when I revoke the authorization in writing.

Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying the Benefits Fund Office in writing. I further understand that the revocation is effective only after it is received at the Benefits Fund Office and that any use or disclosure made prior to the revocation will not be affected by the revocation.

Voluntary. I understand that I am under no obligation to sign this authorization form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

Benefits Not Conditioned on Authorization Form. I understand that eligibility for benefits is not conditioned on this authorization form.

Potential for Redisclosure. I understand that after my health information is disclosed, Federal law might not protect it, and the recipient might re-disclose it.

Right to Copy. I understand that I am entitled to receive a copy of this authorization.

Photocopy and Facsimile. A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

Purpose of Disclosure: This form authorizes the Plan to disclose my personal health information to the person(s) designated pursuant to my individual request.