

I.B.E.W. LOCAL 269 PENSION FUND
C/O I.E. SHAFFER & CO.
P.O. BOX 1028
TRENTON, NJ 08628-0230
PHONE (609) 718-1332 FAX (609) 530-1331

Application For Benefits

(Please Print or Type)

INSTRUCTIONS:

- a. Read and complete all sections of this application.
- b. Complete and attach IRS Form W-4P
- c. Both you and your spouse must sign this application and your signatures must be witnessed by a Notary Public.
- d. Submit acceptable proof of date of birth for yourself and your spouse, if any, such as birth certificate, baptismal certificate or naturalization record. If you are married, submit a copy of your marriage certificate.
- e. If you are applying for a Disability Benefit, submit a copy of your Award Certificate from Social Security indicating that you have qualified for federal disability retirement.

SECTION I - Type of Benefit For Which You Are Applying

I hereby apply for (check one) to become effective _____ 1st, 20 _____
(Month) (Year)

_____ Normal Retirement

_____ Early Retirement

_____ Disability Benefit

Nature of Disability _____

Date Total Disability Started ____/____/____

Date Applied For Social Security Benefits ____/____/____

SECTION II - Personal Information

Name of Applicant _____ Soc Sec # _____

Street Address _____

City, State, Zip _____

Date of Birth ____/____/____ Telephone # () _____

Date Last Employed ____/____/____ Last Employer _____

Marital Status (circle one): Single Married Divorced Widow(er)

Name of Spouse _____

Spouse's Soc Sec # _____ Spouse's Date of Birth ____ / ____ / ____

If you have ever been divorced, please indicate whether a portion of your benefit has been assigned to an alternate payee under a Qualified Domestic Relations Order (QDRO):

_____ Yes, I have a QDRO (Please provide a copy)

_____ No, I do not have a QDRO

SECTION III - Form of Payment

You may elect to receive your benefits under one of the following forms of payment. Please elect the form of payment you desire by checking the applicable box below:

1. _____ **Spouse's Joint and 50% to Survivor Life Annuity** - I have a spouse to whom I am lawfully married and want my pension paid to me under this form of payment. I will receive a reduced monthly pension benefit during my lifetime, with the provision that if I am survived by my spouse, she or he will receive 50% of such reduced monthly pension benefit for the remainder of her or his lifetime. The reduction in my monthly pension benefit depends on my age and my spouse's age. If there is five or less years of difference in our ages, the reduction will be 10% (20% if I am applying for Disability Retirement) and will be increased (decreased) by .5% for each additional year that my spouse is younger (older) than me. Should my spouse predecease me, my monthly pension benefit will be increased to the amount payable to me under the Full Life Annuity Form of payment.

2. _____ **Spouse's Joint and 75% to Survivor Life Annuity** - I have a spouse to whom I am lawfully married and want my pension paid to me under this form of payment. I will receive a reduced monthly pension benefit during my lifetime, with the provision that if I am survived by my spouse, she or he will receive 75% of such reduced monthly pension benefit for the remainder of her or his lifetime. The reduction in my monthly pension benefit depends on my age and my spouse's age. If there is less than one year difference in our ages, the reduction will be 15% (25% if I am applying for Disability Retirement) and will be increased (decreased) by .5% for each additional year that my spouse is younger (older) than me. Should my spouse predecease me, my monthly pension benefit will be increased to the amount payable to me under the Full Life Annuity Form of payment.

3. _____ **Spouse's Joint and 100% to Survivor Life Annuity** - I have a spouse to whom I am lawfully married and want my pension paid to me under this form of payment. I will receive a reduced monthly pension benefit during my lifetime, with the provision that if I am survived by my spouse, she or he will receive 100% of such reduced monthly pension benefit for the remainder of her or his lifetime. The reduction in my monthly pension benefit depends on my age and my spouse's age. If there is less than one year difference in our ages, the reduction will be 20% and will be increased (decreased) by .6% for each additional year that my spouse is younger (older) than me. Should my spouse predecease me, my monthly pension benefit will be increased to the amount payable to me under the Full Life Annuity Form of payment. I may not elect this form of payment if I am applying for Disability Retirement.

4. _____ **Full Life Annuity With 60 Payments Guaranteed** - I elect to receive my pension payments for my lifetime with the provision that, if I die before I have received at least 60 monthly payments, the payments will continue to my Beneficiary until a total of 60 monthly payments have been made to me and my Beneficiary.

All forms of benefit are approximately equal in value. This relative value comparison is made by converting the value of the optional forms to the single life annuity form using interest and life expectancy assumptions. While all comparisons are based on average life expectancies, the relative value of payments ultimately made under an optional form will depend on actual longevity. Current actuarial assumptions used to calculate the relative value of optional forms of benefits will be provided upon your request.

SECTION IV - Beneficiary Designation

(Do not complete this section if you have elected the Spouse's Joint and 50%, 75% or 100% to Survivor Life Annuity. Your spouse is automatically your beneficiary.)

I hereby designate the following Beneficiary to receive any death benefits under the Plan:

Beneficiary _____ Relationship _____

Address of
Beneficiary _____

Social Security # of Beneficiary _____

If the above Beneficiary is not living when I die or does not live to receive all payments due, then the death benefit or remaining payments shall be paid to the following Contingent Beneficiary:

Contingent
Beneficiary _____ Relationship _____

Address of
Contingent Beneficiary _____

Social Security # of Contingent Beneficiary _____

SECTION V - Income Tax Withholding

The benefits you receive under this Plan will be subject to Federal Income Tax. Compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requires that certain conditions be met with regard to Federal Income Tax Withholding. If you elect not to have withholding apply to your payments, or if you do not have enough Federal Income Tax withheld from your payments, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient. Please note that withholding is a method of paying taxes and does not increase or decrease your taxable income, or the total amount of taxes that you pay.

Federal Income Tax

You must complete and include with this application IRS Form W-4P. This form is available on the internet at the following link: <https://www.irs.gov/pub/irs-pdf/fw4p.pdf>

Your Federal Income Tax withholding will be calculated from your completed IRS Form W-4P. If you want to elect to not have Federal Income Tax withheld from your payments, you must still complete IRS Form W-4P and indicate this election on the form as detailed in the instructions for the form.

If you do not provide a completed IRS Form W-4P, Federal Income Tax withholding at the single rate with no adjustments will be made from your payments (regardless of your marital status).

State Income Tax (NJ only)

- A. _____ I elect to have \$ _____ withheld from my payments.
- B. _____ I elect to have _____ % withheld from my payments.
- C. _____ I do not want to have State Income Tax withheld from my payments.

SECTION VI - Direct Deposit Arrangements (REQUIRED FOR MONTHLY PAYMENTS)

So that your monthly benefit payment can be forwarded directly to your bank and deposited to your checking or savings account, please complete the information below: **If possible, it is preferable to simply attach a voided blank check (provided it bears the magnetic numbers along the bottom) to this section of the application.**

_____	_____
(Name of Bank)	(Account Number)
_____	Account Type: ___ Checking
(Street Address)	(Check One Only) ___ Savings
_____	_____
(City, State, Zip)	(Bank's ABA Number)

I authorize the I.B.E.W. Local 269 Pension Fund (the "Plan") to initiate credit entries to my designated account shown above (this includes authorization to correct any entries made in error). I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization will remain in full force and effect until the Plan has received written notification from me to change it in such time and manner as to afford the Plan and Bank a reasonable opportunity to act.

SECTION VII - Signature

I understand and agree to the following:

- A. If after I retire, I again accept employment in the Industry or work for an employer in a capacity for which employer contributions must be made to the Pension Fund, I shall, within one week thereafter, notify the office of the Pension Fund in writing.
- B. If I am receiving a disability pension, the Trustees may require me to have physical examinations, but not more than once in any period of six months and not after I have attained age 62. If I recover from total and permanent disability before age 62, my disability pension will stop.
- C. I will furnish to the Board of Trustees any information or proof requested by it and reasonably required to administer the Plan.
- D. I hereby agree to sign the necessary authorization form for the Trustees to receive from the Social Security Administration the identities of all my employers and periods of employment since the inception of the F.I.C.A. if needed to verify my work in the Industry.

(Signature of Applicant)

