Western Metal Industry Pension Fund

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124

Phone (206) 664-7300 or (800) 426-7132 • Fax (206) 695-0984 • Website: www.wmipension.org

Administered by
Welfare & Pension Administration Service, Inc.

APPLICATION FOR RETIREMENT BENEFITS

[NOTE: Application must be at the Administration Office at least 60 days prior to the effective date requested below.]

[Please print in ink or type.]

NAME:_____ SOCIAL SECURITY NO.: _____
Last First Middle Initial

LIST OTHER LAST NAME(S)/MAIDEN NAME(S) USED:_____ DATE OF BIRTH: _____

MAILING ADDRESS: _____
Street and Number City State Zip Code

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____ EMAIL ADDRESS:_____

CONTACT PERSON OTHER THAN SPOUSE:_____ (_____) _____
Name Phone

UNION LOCAL NO.:_____ MOST RECENT EMPLOYER (whether or not in Plan):_____
Name of Company City

DATE LAST WORKED **OR** DATE YOU INTEND TO TERMINATE PRESENT EMPLOYMENT: _____

RETIREMENT BENEFITS TO BE EFFECTIVE - 1ST DAY OF:_____/_____
Month **Year**

(Please note that the earliest effective date you can elect is 60 days after the first of the month following our receipt of this application.)

MARITAL STATUS: SINGLE ☐ *DIVORCED ☐ *WIDOWED ☐ *REMARRIED ☐ MARRIED ☐

***If widowed, you must submit a copy of the spouse death certificate. If divorced/remarried, you must submit a complete copy of your final divorce decree(s) and any related "qualified domestic relations order" (QDRO).**

NAME OF SPOUSE: _____ SPOUSE SOCIAL SECURITY NO.: _____
First Middle Initial Last, if different

SPOUSE DATE OF BIRTH: _____ DATE MARRIED: _____

IF YOU ARE APPLYING FOR DISABILITY RETIREMENT BENEFITS PRIOR TO AGE 55, CHECK THIS BOX: ☐

NOTE: You will be furnished with an election of benefit form showing your various benefit options between 30-90 days prior to your retirement effective date. Your completed, notarized election of benefit form must be received prior to your effective date.

This application may be canceled, in writing, at any time prior to the disbursement of the initial benefit payment.

I understand that my eligibility to receive the benefit requested herein is governed entirely by the provisions of the retirement plan or as the same may hereafter be amended, and that the payment to me of any amount in excess of that to which I am entitled will be recovered by the plan.

NOTARIZATION

Subscribed and sworn to before me_____
this day of_____, 20 _____
Notary Signature _____
Notary Public in and for the State of _____
Residing at _____
My commission expires _____

[All unmarried and disability applicants must have signatures notarized.]

_____
PARTICIPANT SIGNATURE

DATE: _____

[Unmarried and disability applicants, please see Page 3.]

EMPLOYMENT HISTORY

The Western Metal Industry Pension Fund is a multi-employer, multi-craft pension plan. Therefore, you should list all employers for which you have worked, and indicate all local unions regardless of whether you believe they were covered under this plan. You must furnish at least approximate dates of employment with each employer. Your employment history will be verified from all available sources; however, the final burden of submitting proof shall rest with you.

List your present employer first. Then list all previous employers in reverse order. Report any periods of six or more months in which you were unemployed and state the reason. Also include any periods you worked for an employer in a non-bargaining unit capacity. If more space is needed, use additional sheets of paper and attach them to this application.

The employment history is an important part of your retirement application. It assists the administration office in determining whether all applicable forms of service have been reported on your behalf.

NAME OF EMPLOYER /CITY	POSITION OR JOB TITLE	LOCAL UNION NUMBER (if any)	FROM (Month / Year)	TO (Month / Year)
PRESENT EMPLOYER 1.				
PREVIOUS EMPLOYERS 2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

A Break-In-Service due to service in the Armed Forces of the United States may be canceled if a participant submits as proof a photocopy of their DD-214 Military Discharge form. Enter below all dates of any United States military service.

Branch of Service:	From (Month / Year):	To (Month / Year):

✓ INSTRUCTIONS FOR FURNISHING PROOF OF AGE

At the time you submit this completed application to the pension office, or as soon as possible thereafter, you must furnish proof of age:

Either ONE of these documents

- Birth certificate
- Hospital birth record
- Infant Baptismal Certificate
- Any governmental agency record of birth certified by that agency's custodian
- Naturalization record
- Immigration papers

OR any TWO of these documents

- Military records
- Passport at least 10 years old
- School records certified by custodian of record
- Insurance policy, at least 10 years old, showing age or date of birth
- Marriage records showing age or date of birth
- Notarized affidavits by persons having knowledge of your date of birth

Note: If you are married and elect a spouse option form of payment, you must submit proof of age for your spouse as described above at the time you make an election. A copy of your marriage certificate will also be required if you elect a spouse option.

✓ BENEFICIARY DESIGNATION FOR UNMARRIED PARTICIPANT

Please designate your beneficiary below. **Note that <u>you</u> as the participant must sign this section. Do not have your beneficiary sign**. You may list more than one beneficiary. However, you may <u>not</u> designate an institution or your estate as your beneficiary.

NAME OF BENEFICIARY:_____
Last First Middle Initial

ADDRESS: _____
Street and Number City State Zip Code

SSN OF BENEFICIARY:_____ DATE OF BIRTH:_____ PHONE NO.: _____

RELATIONSHIP:_____ PARTICIPANT SIGNATURE:_____ DATE:_____

✓ DISABILITY RETIREMENT

If you are applying for disability retirement benefits, medical proof of total and permanent disability is required, for which we will contact your physician. You must complete the authorization to release medical information on Page 4 of this form. If your application is approved, you will be provided with an Election of Benefit form, which lists the available forms of payment.

Have you applied for Social Security Disability? Yes ☐ No ☐ If you have an approval letter, please provide a copy.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO THE WESTERN METAL INDUSTRY PENSION FUND

Complete this page only if you are applying for **disability retirement** benefits.

MEDICAL SOURCE (PHYSICIAN'S NAME, ADDRESS, PHONE AND FAX NUMBER):

_____

_____

_____

APPLICANT'S NAME AND ADDRESS: _____

_____

_____

APPLICANT'S TELEPHONE NO.: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

PERIOD OF TREATMENT: FROM _____ **TO** _____

AUTHORIZATION

I hereby authorize the above named medical source to disclose medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition (including psychological or psychiatric impairments) during the period(s) identified above to the Western Metal Industry Pension Fund. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for disability benefits under the retirement plan of the Western Metal Industry Pension Fund.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the organization providing the information.

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- Information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurance from the above-named person/organization authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

I UNDERSTAND THAT IF THE MEDICAL SOURCE CHARGES A FEE FOR ITS REPORT, I AM RESPONSIBLE FOR PAYING THE FEE.

_____ _____

Signature of Applicant (or person acting on his/her behalf) Relationship to Applicant

_____

Date