I.B.E.W. Local No. 81 Annuity Fund
APPLICATION FOR BENEFITS

Fabian & Byrn , 425 Eagle Rock Ave, Ste. 105, Roseland, NJ 07068
P: 888-335-0133 | F: 973-228-4240

Please complete and return with the copies requested below * *Complete both sides*

Participant Name:____ **Date of Birth:** ______________________

Address:____ **Phone #** ___________________________

____ **Soc. Sec. #** _________________________

Date last worked in I.B.E.W. trade (in or out of Local 81 jurisdiction):_________________________________

Last employer for whom you worked: ____

TYPE OF BENEFIT APPLIED FOR

( ) Termination of covered employment** for more than six (6) consecutive months to receive a maximum benefit of $7,500 per month, payable as a series of monthly lump sums

( ) Termination of covered employment** for more than nine (9) consecutive months to receive all monies

( ) Normal Retirement Effective Date ____________________
Please provide proof of retirement if not from Local No.81, such as an approved pension application or letter from your home local

( ) Disability Retirement Effective Date _______________________
Requires a six (6) month consecutive break in service. You will be required to submit medical evidence of total disability in a form satisfactory to the Board, and a copy of your Social Security Award letter.

Are you married? ( ) **Yes** ( ) **No** If yes, provide the following information for your spouse:

Spouse Name____ Date of Birth ________________________

Soc. Sec. # ____

PARTICIPANT SIGNATURE____**Date**______________________

*** Provide copies of the following documentation for you <u>and also for your spouse</u> (if you are married):**

1. **Proof of Birth (birth certificate <u>or</u> driver's license showing date of birth)**
2. **Marriage Certificate/License**
3. **Social Security cards**

**** Covered Employment includes work in the jurisdiction of Local 81 and reciprocal work from other I.B.E.W. locals providing contributions into this Fund.**

YOUR COMPLETED APPLICATION MUST BE RECEIVED BY THE 10TH OF THE MONTH IN ORDER FOR A CHECK TO BE MAILED BY THE FIRST DAY OF THE FOLLOWING MONTH.

I.B.E.W. Local No. 81 Annuity Fund

Participant Name: ____

Social Security Number ____

Complete **Election A** if you want all or a portion of your distribution made payable to you, subject to federal income tax withholding and state tax regulations.

Election A

I elect to have________**% or $**______________of the distribution made payable to me. I understand that 20% of the taxable portion of the distribution will be withheld. A balance of less than $5,000 will be issued in a total lump sum.

I understand that 20% of the taxable portion of the distribution will be withheld for Federal Income Tax.

Distributions other than rollovers into a new account are subject to mandatory federal income tax withholding. Federal taxes will be withheld at a minimum rate of 20%. To request a higher rate, specify a whole number above 20% below. You may also select a withholding election for state taxes below. This option is not available in all states. Your state withholding election will be overridden if it conflicts with the individual state requirement for withholding.

Federal Tax Withholding: _______% (must be a whole percent greater than 20%)
State Tax Withholding: _______% (select 0% if you would like no state tax withholding)

Election A Participant Signature____**Date:**________________

If you elected the distribution payable to you, go no further

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Complete **Election B** if you are requesting a "direct rollover" of any portion of the distribution to an "eligible retirement plan."

Election B

I elect a direct rollover of________**% or $**______________of the distribution is to be made to the following "eligible retirement plan" (***CHECK ONE***):

☐ **Qualified Employer Plan** ☐ **IRA**

Name of IRA Custodian or Qualified Plan ____

Address of IRA Custodian or Qualified Plan

____

Account No. (if applicable) ____

Indicate below the address to which this rollover check is to be mailed:

____

I confirm that the above named eligible retirement plan is an individual retirement account established in my name, or a qualified retirement plan that accepts direct rollovers.

Election B Participant Signature____**Date:**________________

Form 1099R will be issued at the end of the calendar year that payment is made and will be sent to your home address.

CONTRACT ADMINISTRATOR SIGNATURE:________________________________DATE ________________