PENSION APPLICATION

ALL ALASKA LONGSHORE PENSION TRUST
PMB #116 5331 S Macadam Ave Suite 258
Portland, OR 97239
Toll Free 1-800-547-4458 or
(503) 224-0048 in Portland

This is your application for Pension Benefits. It is recommended that your application and the best possible proof of age which can be obtained, be sent to the office listed above at least TWO MONTHS in advance of the first of the month in which you want your pension benefit payments to begin. Benefits will not be payable until the first of the month following termination of employment. A requirement of retirement is that you de-register.

The accuracy and completeness of the information you send with your application will speed the processing of your application and provide faster payment of the benefits to which you may be entitled. Please answer all questions carefully. If you have any questions on completing and submitting this application and/or proof of age, please call on the Administrative Office for assistance.

Along with the completed application you should also submit the following items:
A copy of your Birth Certificate
If married, a copy of your spouse's Birth Certificate
If married, a copy of your Marriage Certificate
If divorced, a copy of the Divorce Decree
If widowed, a copy of the Death Certificate for your spouse
If disabled, a copy of your Social Security Disability Award
Completed de-registration form

I hereby apply for: (check one box)

☐ POSTPONED RETIREMENT ☐ NORMAL RETIREMENT

☐ EARLY RETIREMENT ☐ DISABILITY RETIREMENT

EFFECTIVE DATE OF RETIREMENT: _____

(*Must be the 1st day of a month)*

_____ _____

Signature of Participant Date

Be sure you answer every question in full and as accurately as possible. AN INCORRECT OR INCOMPLETE APPLICATION WILL DELAY BENEFIT PAYMENT. PLEASE BE SURE TO INCLUDE ALL DOCUMENTS REQUESTED, AS NO PROCESSING CAN BE DONE ON YOUR FILE UNTIL ALL DOCUMENTS HAVE BEEN OBTAINED.

1. Full name you use at work: _____

   (a) Name given you at birth: _____

   (b) Have you ever worked under a different name? [ ] Yes [ ] No
   (If yes, attach a statement giving the dated name was used so that your work record can be verified properly.)

2. Permanent mailing address: _____

_____

3. Telephone number: _____

4. Local Union number/Region: _____

5. Social Security Number: _____

6. Sex: ☐ Male ☐ Female

7. Date of birth: _____*(Attach proof of age)*

8. Marital Status: ☐ Married ☐ Single *(never married)*
   ☐ Divorced ☐ Widowed

(Evidence of marital status must be submitted, i.e., marriage certificate, divorce decree, death certificate, etc.)

   (a) If divorced, was your (ex)spouse awarded any part of your pension benefit in your settlement? ☐ Yes ☐ No *(If yes, submit evidence of such.)*

9. Spouse's full name: _____

   (a) Has spouse been previously married? ☐ Yes ☐ No
   (If yes, list all names previously used: _____

10. Spouse's Date of Birth: _____ *(Attach proof of age)*

11. Spouse's Social Security #: _____

12. Date of Marriage: _____ *(Attach proof of marriage)*
13. Date expected to be your last active day of employment in the industry:

_____

14. Date on which you would like your pension benefits to begin: _____

_____*(Must be the 1st day of a month)*

15. Are you currently working? ☐ Yes ☐ No

If yes, who is your employer? _____

If no, who was your last employer? _____

16. COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR A PERMANENT DISABILITY PENSION BENEFIT: *The Board of Trustees may ask you to submit to an Independent Medical Examination prior to making a decision on your eligibility for disability benefit.*

(a) Nature of your disability: _____
(Submit a letter from your attending physician regarding your total & permanent disability)
(b) Date your first became disabled: _____

(c) Name & address of your doctor: _____
(d) If you have worked at any occupation since you became disabled, describe the work and periods of employment: _____

_____

(e) What is your job title? _____

(f) Are you receiving Social Security Disability Benefits? ☐ Yes ☐ No
If the answer is "yes", attach a copy of your award from Social Security.

Have you applied for Social Security Disability benefits? ☐ Yes ☐ No
If the answer is "no", will you be applying for Social Security Disability Benefits? ☐ Yes ☐ No

(g) Are you or have you received any benefits under any Worker's Compensation law, IBU-Alaska Welfare Plan Time Loss (weekly indemnity) or benefits by reason of military service? ☐ Yes ☐ No

If the answer is "yes", please state the period of time for which you received this benefit, and the amount that you received monthly: _____

_____

RECIPROCITY

This plan has reciprocity agreements with some other pension plans. Please list below any other areas in which you worked in the industry. Attach a separate sheet is needed.

Union/Region	Name of Pension Plan & Address	Period of Time

List below period(s) of employment when you DID NOT work in the industry: *(Advise the employer in the other industry, disability, military service, other reasons.)*

_____

BENEFICIARY DESIGNATION

I, the undersigned hereby designate:

Primary Beneficiary:

Name: _____

Address: _____

_____

Social Security #:_____

Date of Birth: _____Relationship: _____

Secondary Beneficiary: *(Please name a Secondary Beneficiary in case the Primary Beneficiary passes away prior to your death.)*

Name: _____

Address: _____

_____

Social Security #: _____

Date of birth: _____Relationship: _____

(If additional space is needed, please attach a signed statement naming of additional beneficiaries to this application.)

In the order listed above, to be the beneficiary of any benefits payable by the Trust in the event of my death. I understand that this beneficiary designation will apply unless my pension benefit is being continued under the Contingent Annuity Form.

I hereby certify that the information given in this application is true and correct to the best of my knowledge.

_____ _____

Date Signed Signature of Applicant

RETURN TO WORK AFTER RETIREMENT RULES
ALL ALASKA LONGSHORE PENSION TRUST

IF YOU RETURN TO WORK: Should you return to work after you begin receiving a pension benefit, benefits will be suspended for any month in which you work 40 or more hours in industry service. You will accrue additional benefits if you accrue at least 200 hours in a Plan Year (January through December).

NOTIFICATION OF EMPLOYMENT FOLLOWING RETIREMENT: You musts notify the Plan when you become re-employed in work which could cause your pension to be suspended. And you must notify the Plan when your work ends, so pension benefits can be resumed. If you do not notify the Plan when you become re-employed in industry service, the Plan will presume that you had at least 40 hours of such employment during each month you worked.

DISABILITY RETIREES WHO RETURN TO WORK WILL HAVE IMMEDIATE SUSPENSION OF BENEFITS.

I have read the above rules regarding return to employment after retirement, and do fully understand these rules, and hereby wish to make application for retirement.

_____	_____	_____
Signature of Participant	Social Security #	Date