

Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension



APPLICATION FOR DEFINED CONTRIBUTION DEATH BENEFITS

Personal Information Regarding Deceased Participant:

Full Name: _____ Social Security #: _____

Address: _____

Date of Birth: _____ Local Union #: _____

Last Date Worked: _____ Name of Last Employer: _____

Information Regarding Beneficiary:

Full Name: _____ Social Security #: _____

Address: _____

Email Address: _____ Home Phone #: _____

Date of Birth: _____ Cell Phone #: _____ Relationship: _____

Note: Pension benefit which may be payable under the Pension Plan will be mailed to the beneficiary at the above address, unless otherwise indicated.

I hereby certify that I am the beneficiary of _____,
(Deceased Participant's Name)

and that the above information, to the best of my knowledge and belief, is true and complete. **Before final action is taken on this application, I understand it will be necessary for me to provide the Administration office with a Death Certificate, my photo ID and birth certificate.**

Beneficiary's Signature

Date

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ELECTION OF OPTIONS

I hereby acknowledge that I understand my rights to benefits from the Northern California Tile Industry Defined Contribution Plan. I hereby elect to receive my benefits in the form indicated below.

I hereby choose to receive payment in the option as indicated below:

LUMP SUM PAYMENT

Any amount that is an eligible rollover distribution is subject to mandatory 20% withholding for Federal Income Tax if the amount is paid directly to you.

All of Account balance

Signature: _____ Date: _____

DIRECT ROLLOVER:

Inherited IRA Account

Name of IRA: _____

Account Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Contact: _____

Signature: _____ Date: _____

*****DO NOT WRITE BELOW THIS LINE*****

ADMINISTRATOR AUTHORIZATION

Authorized Fund Administrator Signature

Date

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566
P.O. Box 1607 San Ramon, CA 94583
Phone 925.208.9995 • Toll Free 888.208.0250 • Facsimile 925.462-0108
www.bac3tilebenefits.org • staff@bac3tilebenefits.org

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STATE INCOME TAX WITHHOLDING ELECTION

State: _____

(Please specify State)

Please Elect One: :

- Please withhold State income tax from my distribution at the rate of 10% of the amount withheld in Federal Income Tax.
- Please withhold \$_____ from my distribution in State income Tax
- Please DO NOT withhold any State income tax from my distribution.

Signature

Date

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