

Indiana State Council of Carpenters Benefit Distribution Application

How to properly complete the Benefit Distribution Application

Benefit Distribution Application for Retirement Benefits

APPLICATION FOR RETIREMENT BENEFITS

I hereby apply, under the Plan of the INDIANA STATE COUNCIL OF CARPENTERS PENSION FUND, for:

- Normal Retirement Benefit
- Early Retirement Benefit (Including Unreduced Early)
- Deferred Vested Retirement Benefit

Desired Effective Date: First day of _____, _____
(Month) (Year)

Please note, this application will be valid only if returned to the Fund Office within 30 days of your effective date. Your effective date will be no sooner than the first of the month after your application has been received in the Fund Office.

I hereby submit the following personal information about me and my spouse:
(Please type or print):

Participant Information:

Name _____

Social Security Number _____ Date of Birth _____

Full Address _____

Home Phone Number _____ Alternate Phone Number _____

The date you last worked or the date you last expect to work before retirement _____

Please list any other Local that you have worked for: _____

Spouse Information:

Name _____

Social Security Number _____ Date of Birth _____

Date of Marriage: _____

Check one

Write which month and year of retirement

Fill out completely

Must fill out Last Date Worked (MM/YY)

Fill out completely



Benefit Distribution Application for Retirement Benefits

Must be signed and dated,
must be returned with all
retirement applications.

CERTIFICATION

I hereby certify that all of the information furnished by me on this application form is, to the best of my belief and knowledge, true and complete. I understand that this completed application form will be attached to and become part of my application for benefits and that when I submit such application, I must also submit acceptable proof of my age and, if I am married at that time, proof of my spouse's age and a copy of our marriage certificate. I understand that if I have ever been divorced and/or widowed, I must also provide the Fund Office with a complete copy of all of my Judgments of Divorce and/or Qualified Domestic Relations Orders (including Separation Agreements, Property Settlement Agreements and any similar or related orders with any attachments) and/or the death certificate(s) of my late spouse(s) or ex-spouse(s).

I also agree that Pension payments are to be governed in all respects by the provisions of the Plan, or as same may hereafter be amended, and that the issuance of any Pension payment and its acceptance by me shall not prevent the Fund from recovering, or otherwise affect its right to recover, any payments issued to me in excess of the amount to which I am entitled under the provisions of the Plan, nor shall the issuance of any Pension payments to me obligate the Fund in any way to make any further payments in any amount whatsoever except as the same may be provided by the Plan as it may be amended from time to time.

Your Signature _____ Date _____

RETURN WITH:

- Certification of Marital/Single Status Form
- Withholding Certificate for Pension/Annuity Payments (W-4P/ Federal Tax Form)
- Indiana State Tax Form
- Direct Deposit Agreement
- Copy of your birth certificate and Photo ID
- Copy of your spouse's birth certificate and Photo ID, if applicable
- Copy of your Marriage Certificate
- Copy of any and all previous divorce decrees, Qualified Domestic Relations Orders, Separation Agreements, death certificates for previous spouse(s), etc

Please review the forms you are submitting to make sure that you have completed all blanks, signed where necessary, including the signature of a notary public where applicable, and answered the questions accurately and completely.

You can email all documents back to retire@benesys.com OR
You can fax all documents back to 248-721-9678

Mailing address is Indiana State Council of Carpenters PO BOX 969 Troy, MI 48099

Benefit Distribution Application for Retirement Benefits

For married participants,
this must be signed and
dated when the application
is received.



Indiana State Council of Carpenters' Pension Fund

P.O. Box 969, Troy, MI 48099-0969
Phone: (800) 700-6756

STATEMENT OF APPLICATION RECEIPT

(Married participants ONLY)

In order to comply with Federal Regulations related to the 30-day waiver form (enclosed with this application), the Fund Office must have a statement from you indicating the date you received an explanation of your benefit options.

Please indicate the date you received this application packet: _____

Your Signature: _____

(please return with your application)



Benefit Distribution Application for Retirement Benefits – Certification of Marital/Single Status

This form must be completed by the member, *regardless of marital status.*

If there are any previous marriages, they must be listed with the date of marriage and date of divorce or death. Provide complete copies of ALL documents required as listed here, if applicable.

Form must be notarized regardless of marital status; do not sign until in front of a notary. Dates of participant signature and notary must match. Notary must sign on signature line.

CERTIFICATION OF MARITAL/SINGLE STATUS oh

Federal Law requires the Trustees to confirm whether a previous spouse is entitled to any portion of your pension benefits. As such, it is necessary that we request the following certification and supporting documentation. Failure to complete this form fully, including signing it in front of a notary public, and providing ALL documentation requested, will result in a delay of the processing of your application.

Participant Name: _____ S.S. #: _____

- Current marital status:
- SINGLE, never married
 - SINGLE, previously married*
 - MARRIED, no previous marriages
 - MARRIED, with previous marriages(s)*
 - WIDOWED

*If you have had previous marriages, please list the names of your ex-spouses, the date(s) of marriage and date(s) of divorce (if any of your previous marriages ended due to the death of your spouse at the time, please list the date of death):

<u>Ex-spouse's Name</u>	<u>Date of Marriage</u>	<u>Date of Divorce/Death</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide complete copies of ALL, divorce decrees, separation agreements, Qualified Domestic Relations Orders and any other accompanying documents related to the termination of your previous marriage(s). If any previous spouses have passed away, please provide a copy of the death certificate(s). If you do not have these documents, you should contact the appropriate court through which the proceedings occurred in order to obtain certified copies. For additional ex-spouses, please use the back of this form.

I hereby certify, subject to the penalty of perjury, that the above information is, to the best of my belief and knowledge, true and complete. ANY PERSON WHOM SUPPLIES A FALSE CERTIFICATION IN CLAIMING A BENEFIT COMMITS A CRIMINAL ACT UNDER 18 U.S.C. SECTION 1027 AND ERISA LAW, FORFEITS ANY RIGHT HE OR SHE MAY HAVE TO THE BENEFIT AND, UPON DISCOVERY, BECOMES LIABLE FOR FULL REPAYMENT OF ANY MONEY RECEIVED AS A CONSEQUENCE.

Participant Signature _____

Today's Date _____

Place Notary Stamp/Seal
Or
Authorized Fund Representative's Signature Here

Subscribed to and sworn to before me,
This _____ day of _____, 20__

(Signature)
Notary Public, _____ County

State of _____ My Commission Expires on _____

*Notice to Notaries: Federal Law (i.e., the Retirement Equity Act of 1984) requires that the above Form must be executed in the presence of an authorized Plan representative or a Notary Public. Accordingly, it is most important that you not only witness the actual signature identified above, but also examine their credentials to satisfy yourself that they are, in fact, the same persons as the ones identified.



Benefit Distribution Application for Retirement Benefits – Waiver of 30-Day Notice

For married participants only. Both the member and spouse must sign in front of a notary. Dates must match the notary signature.

WAIVER OF 30 DAY NOTICE REQUIREMENT

I, _____, hereby acknowledge that I have been informed that federal law prohibits the Fund from paying benefits to me until at least 30 days after my spouse and I have received a written explanation of the 50%, 66 2/3%, 75% and 100% Qualified Joint and Survivor forms, including my right to waive those forms and elect a Single Life Annuity or Single Life/ Five-Year Certain; Ten-Year Certain; Fifteen Year Certain and Twenty Year Certain form with the written consent of my spouse, the effect of such a waiver and the right my spouse and I each have to revoke that waiver and consent. I have also been informed that I may waive that 30 day notice period and instead elect a 7 day notice period, which will permit the Fund to commence payment of benefits to me no less than 7 days after my spouse and I received the written explanation, provided my spouse also consents in writing to waiver of the 30 day notice period.

{ } I elect to waive the 30 day notice period.

Date Your Signature

Witnessed by:

Authorized Plan Representative or Notary Public*

SPOUSAL CONSENT TO WAIVER OF 30 DAY NOTICE REQUIREMENT

I am the legal spouse of _____. I acknowledge that I have been informed that my spouse wishes to waive the requirement that we receive, at least 30 days before the Fund pays benefits to my spouse, a written explanation of the 50 %, 66 2/3, 75% and 100% Qualified Joint and Survivor forms, including my spouse's right to waive those forms and elect either a Single Life Annuity or Single Life/ Five, Ten, Fifteen or Twenty-Year Certain form with my written consent, the effect of such a waiver and the right my spouse and I each have to revoke that waiver and consent, and to elect instead a 7 day notice period as permitted by federal law. I hereby consent to the election of my spouse to waive the 30-day notice period.

Date Spouse's Signature

Witnessed by:

Authorized Plan Representative or Notary Public*

*Notice to Notaries: Federal Law (i.e., the Retirement Equity Act of 1984) requires that the above Waiver must be executed in the presence of an authorized Plan representative or a Notary Public. Accordingly, it is most important that you not only witness the actual signatures identified above, but also examine their credentials to satisfy yourself that they are, in fact, the same persons as the ones identified.

Benefit Distribution Application for Retirement Benefits – Direct Deposit Agreement

Fill out completely

Must check account type:

Fill out completely, sign and date

Fill out if applicable

Must include a voided check

DIRECT DEPOSIT AGREEMENT

Name of Payee _____ Social Security No _____
 Address _____
 City _____ State _____ Zip _____
 Telephone No () _____

Bank Account Information – Attach a voided check from your account and/or complete the information below. See sample check at the bottom of the page for help completing this section. PLEASE PRINT CLEARLY.

Routing No. Account No. _____

Type of Account: Checking Savings

Financial Institution
 Name _____
 Address _____ Telephone Number _____
 City _____ State _____ Zip _____

I, the undersigned, hereby authorize the Board of Trustees of the Pension Trust Fund ("the Pension Fund") to deposit all amounts due to me under the Pension Plan in my account at the Financial Institution named above. This authorization shall remain in force until I revoke it in writing or until my death, whichever occurs first. If at any time the Pension Fund should credit my account for a benefit to which I am not entitled, I authorize and direct the Financial Institution to refund the Pension Fund.

Payee Signature _____ Date _____

Please allow up to 45 days for the direct deposit set-up process to be completed.

ATTENTION Surviving Spouses, Beneficiaries, and Alternate Payees: You are receiving this pension benefit as a Beneficiary of a Participant in the pension fund, therefore, please write the name and social security number of that Participant below:
 Participant: _____ Social Security No. _____

RUFUS MAPLE
MARY MAPLE
 123 Main Street
 Anyplace, LA 70000

1234
 18 00000000

PAY TO THE ORDER OF \$ _____ DOLLARS

ANYPLACE BANK
 Anyplace, LA 70000

Routing number (line 23bx) _____
 Account number (line 23cj) _____

Do not include the check number

For _____
 1-60250025-00200-86-1234

Fax# 248-721-9678

A760
Indiana State

Note: The routing and account numbers may be in different places on your check.

Benefit Distribution Application for Retirement Benefits – Suspension of Benefits

SUSPENSION OF BENEFITS

IMPORTANT INFORMATION CONCERNING THE SUSPENSION AND RESUMPTION OF BENEFITS

Your benefits can be suspended under certain conditions. Please review the following explanation of these conditions carefully. These conditions are also set out in your Summary Plan Description in more detail. These rules are designed to help the Plan Administrator administer the Plan in accordance with the purposes for which it was formed. **IF, NOW OR IN THE FUTURE, YOU HAVE ANY QUESTIONS CONCERNING THESE RULES, CONTACT THE FUND OFFICE FOR ASSISTANCE.**

Suspension of Benefits

Your benefits shall be suspended if all the following conditions apply to you:

- you are entitled to receive or are receiving a Retirement Benefit, *and*
- you *remain in or return to* employment in the same industry, in the same trade or craft and in the same geographic area, *and*
- you are employed for forty (40) or more hours in a month.

If you meet these conditions, then you are considered to have worked in “suspendable employment.” If you work in suspendable employment then you shall forfeit one monthly pension payment for each calendar month during which you are employed for forty or more hours. If you engage in suspendable employment prior to age 65, any benefits accrued on or after June 7, 2004 will be suspended for an additional three months. If you failed to notify the Plan of employment that may be the basis for suspension of benefits or willfully misrepresented to the Plan with respect to your employment, the monthly benefit shall be suspended for an additional period of six months.

HOWEVER, if you return to work in the same industry, but not in the same trade or craft, for an employer who is signatory to a contract with a subordinate Local Union of the Indiana/Kentucky/Ohio Regional Council of Carpenters, and you are not yet 65, you are not considered to be working in suspendable employment.

Verification of Employment Status

Once you begin receiving or become entitled to receive a Retirement Benefit, you shall be responsible for promptly notifying the Administrator, in writing:

- If you engage in any employment whatsoever, regardless of the number of hours worked per month and regardless of whether you believe such employment to be suspendable employment which would permit suspension of your Retirement Benefit; and
- When you cease any such employment.

You need to make this notification on the forms provided for that purpose by the Plan Administrator. The Plan Administrator shall have the right to request from you access to

all reasonable information for the purpose of verifying your employment status. This information shall include, but not be limited to, all tax withholding statements received by you for the periods in question.

If you are receiving or entitled to receive a Retirement Benefit, the Plan Administrator may also require you either to certify that you are unemployed, or to provide information sufficient to establish that your employment does not constitute suspendable employment, before you receive any future benefit payments.

Presumptions

Whenever a Trustee becomes aware that you are receiving or entitled to receive a Retirement Benefit but are employed and you have not complied with the notification requirements listed herein, *the Trustees shall presume that you were employed by the same Employer for at least forty (40) hours per payroll month during each month that you have been working for that Employer.*

In such a case, your benefits shall be *suspended immediately.* If your benefits are suspended based on such a presumption but you were *not* employed in suspendable employment, you are responsible for demonstrating that you did not work in suspendable employment warranting suspension of benefits during the months in question. If you provide sufficient information to allow the Trustees to conclude that you were not employed as presumed, then at the next regularly scheduled time for payment of benefits you shall receive the full amount of any and all payments which had been withheld pending such determination.

Notice of Suspension of Benefits

The Plan Administrator shall notify you of any suspension of your Retirement Benefit pursuant to these rules. This notice shall be made in writing, by personal delivery or first class mail, during the first calendar month in which your payment is suspended.

Suspension Review Proceedings

If your benefits have been suspended under the aforementioned provisions, you shall be given the opportunity to appeal such suspension. Requests for such review shall be considered in accordance with the claims review procedure set out in your Summary Plan Description.

Advance Status Determination

If you are considering working and you wish to have an advance determination by the Trustees as to whether specific contemplated employment will constitute suspendable employment, you may request the Trustees to make such a determination. The Trustees shall provide you with such a determination within a reasonable time after your request.

Commencement or Resumption of Payments

If your benefits are suspended in accordance with the above conditions, but you cease such suspendable employment, then your benefits can be resumed. When you cease such employment it is your responsibility to notify the Plan Administrator of such. After the Plan Administrator receives this notice from you and verifies that you have ceased such employment, your Retirement Benefit shall commence or resume no later than the first day of the third calendar month after you ceased to be employed in suspendable employment. The benefit you will receive will be the same benefit as you were receiving

when you began suspendable employment the payment scheduled to occur in the calendar month when your payments commence or resume, and

- any amounts withheld during the period between cessation of suspendable employment and the commencement or resumption of payments,
- less any amounts which are subject to offset, as set out below.

Offset Rules

Once your benefit suspension is lifted because you no longer work in suspendable employment, your benefit payments shall be subject to an offset (or deduction) in an amount equal to any payments made to you while you were employed in suspendable employment. The first monthly payment you receive when your benefit payments resume shall be subject to offset without limitation. However, after the first monthly payment has been made, there is a limitation on the amount that can be offset from each monthly payment. Beginning with the second payment and continuing for the remaining payments until the balance of the benefits to be offset is deducted, the offset shall not exceed twenty-five percent (25%) of one month’s total benefit payment which you would have received except for the offset.

THIS SUMMARY OF THE PLAN RULES CONCERNING SUSPENSION OF BENEFITS IS PROVIDED TO YOU IN ORDER TO MAKE CLEAR THESE RULES TO YOU. IN THE EVENT OF A CONFLICT BETWEEN THE PLAN DOCUMENT AND THIS SUMMARY, THE ACTUAL PLAN DOCUMENT CONTROLS.

I, the undersigned, have been given a copy of this summary of the rules of benefit suspension. I have read and understand this summary and these rules. I was given an opportunity to ask any questions concerning this summary and these rules if I had any. If I asked any questions, they were answered to my satisfaction.

_____ DATE	_____ PARTICIPANT SIGNATURE	_____ PRINTED NAME
_____ DATE	_____ WITNESSED BY	_____ PRINTED NAME

Must be signed with a witness. Witness and participant date must match.

Benefit Distribution Application for Retirement Benefits – Retirement Declaration

INDIANA STATE COUNCIL OF CARPENTERS PENSION FUND

Retirement Declaration

This Retirement Declaration must be completed and submitted with your application for benefits before your application is processed. Please read this entire Retirement Declaration carefully before signing.

Federal law requires that you retire to be eligible for pension benefits from the Indiana State Council of Carpenters Pension Fund (the "Plan"). This means you must sever employment with all employers required to make contributions to the Plan. Also, you must refrain from engaging in "Disqualifying Employment."

The Plan generally defines "Disqualifying Employment" as working 40 hours or more in a month in employment (including self-employment) that is:

1. In the same industry in which employees covered by the Plan were employed and accruing benefits under the Plan at the time pension benefits commenced or would have commenced if you were not engaged in Prohibited Employment; and
2. In the same "trade or craft" in which you were employed at any time while covered by the Plan or supervisory activities relating to such trade or craft. Trade or craft extends to any job or occupation using the same skill(s); and
3. In the same geographic area covered by the Plan at the time pension benefits commenced or would have if you were not engaged in Prohibited Employment.

NOTE: Refer to the Plan's Summary Plan Description for exceptions that may apply to the above definition of Disqualifying Employment. Different rules may apply for work performed during certain time periods or in certain employment positions. If you do not have a copy of the Plan's Summary Plan Description, you can request a copy from the Plan Office using the contact information below.

Participant's Retirement Declaration:

I, the undersigned Plan participant, hereby declare my intent to retire and sever employment with all employers that contribute to the Plan. I also declare that I am not currently engaging in Disqualifying Employment as defined in Article VIII, Section 9 of the Plan and summarized above.

By signing this Retirement Declaration, I hereby acknowledge and understand the following:

- I am bound by all of the Plan's rules and regulations.
- Subject to limited and temporary exceptions approved by the Plan's Board of Trustees ("Trustees"), I am not entitled to receive pension benefits in any month I engage in Disqualifying Employment, and my pension benefits will be suspended until I cease engagement in Disqualifying Employment and return to retirement status.
- If I received pension benefits for which I am not entitled (e.g., receipt of pension benefits while engaged in Disqualifying Employment that is not subject to an exception), I am obligated to repay the amount overpaid to me, plus interest, and the Trustees may reduce future pension benefits to recoup the overpayment.

- I must provide written notice to the Trustees within 30 days if I engage in any work of a type that might be considered Disqualifying Employment, without regard to the number of hours worked. The notice must be sent to the Plan Office at the address below and must include the beginning date and nature of the employment engagement.
- If the Trustees learn that I engaged in Disqualifying Employment without providing the required notice described above, the Trustees may presume that I have been engaged in Disqualifying Employment for up to as long as I have received pension benefits from the Plan. Further, if the Trustees learn that I willfully misrepresented my employment status, my pension benefits may be suspended for an additional period of six months.
- If my pension benefits are suspended due to my engaging in Disqualifying Employment, I must provide written notice to the Trustees, including but not limited to a new Retirement Declaration, to reinstate my pension benefits once I am no longer engaged in Disqualifying Employment. The notice must be sent to the Plan Office at the address below at least 30 days before the date I wish to have my pension benefits reinstated. No pension benefits are payable for the months following my cessation of Disqualifying Employment and prior to the Trustees' receipt of my written notice and any required forms.

Please contact the Plan Office if you have questions regarding Disqualifying Employment or to provide a written notice to the Trustees:

Indiana State Council of Carpenters Pension Fund
c/o BeneSys, Inc.
P.O. Box 969
Troy, MI 48099-0969
(800) 700-6756

By signing this Retirement Declaration, I hereby authorize any employer for whom I have worked, any benefit fund in receipt of contributions made by any employer on my behalf or any local union affiliated therewith, to release any information concerning my work history and identity (including but not limited to: dates of employment; photo IDs; birthdate; Social Security Number; Union Identification Number; address information; and signature samples) to the Plan.

Participant Information:

Full name (printed): _____

Social Security Number: _____ Date of Birth: _____

Full Address: _____

Phone Number: _____ Alternate Phone Number: _____

Last day of work before retirement: _____

Participant's Signature Date

Fill out completely, sign and date. Must include last day worked (MM/YY)

Benefit Distribution Application for Retirement Benefits – Withholding Certificate for Periodic Pension or Annuity Payments

Must be completed by all participants.

For tax questions, please contact a Tax Professional.

Form W-4P Withholding Certificate for Periodic Pension or Annuity Payments
 Department of the Treasury Internal Revenue Service
 OMB No. 1545-0074
2026
 Give Form W-4P to the payer of your pension or annuity payments.

Step 1: Enter Personal Information

(a) First name and middle initial _____ Last name _____ (b) Social security number _____
 Address _____
 City or town, state, and ZIP code _____

(c) Single or Married filing separately
 Married filing jointly or Qualifying surviving spouse
 Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Step 2: Income From a Job and/or Multiple Pensions/Annuities (Including a Spouse's Job/Pension/Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. See page 2 for examples on how to complete Step 2.
 Do only one of the following.
 (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; or
 (b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs, minus the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-". . . \$ _____
 (ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this pension/annuity, then enter the total annual taxable payments from all lower-paying pensions/annuities. Otherwise, enter "-0-". . . \$ _____
 (iii) Add the amounts from items (i) and (ii) and enter the total here . . . \$ _____

Step 3: Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):
 (a) Multiply the number of qualifying children under age 17 by \$2,200 3(a) \$ _____
 (b) Multiply the number of other dependents by \$500 3(b) \$ _____
 (c) Add other credits, such as foreign tax credit and education tax credits. Enter the total here 3(c) \$ _____
 Add the amounts from Steps 3(a), 3(b), and 3(c). Enter the total here 3 \$ _____

Step 4: Other Adjustments

(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends 4(a) \$ _____
 (b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here 4(b) \$ _____
 (c) Extra withholding. Enter any additional tax you want withheld from each payment 4(c) \$ _____

No withholding I request that no withholding be withheld from my payments. See *Choosing not to have income tax withheld* on page 2.

Step 5: Sign Here

Your signature (This form is not valid unless you sign it.) _____ Date _____

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10225T Form W-4P (2026) Created 12/4/25

Sign and date. 



Benefit Distribution Application for Retirement Benefits – State of Indiana Annuitant's Request for State and County Income Tax Withholding

Only for members that are residents of Indiana. Must be completed if Indiana resident.

Actual dollar amount must be written, not percentage.

Line A – leave blank

Line B – state tax withholding

Line C – county tax withholding

Line D – total withholding (sum of line B & line C)

For no withholding, write \$0 on all lines.

Form WH-4P
State Form 97365
(R2 / 8-03)

State of Indiana
Annuitant's Request
for State and County Income Tax Withholding
(Please Type or Print Clearly)

Full Name _____ Social Security Number _____
Home Address (number and street) _____
City, State, and Zip code _____

A. Annuity contract claim or identification number..... A. _____
B. Enter the amount of Indiana state tax to be withheld from each annuity or pension payment..... B. \$ _____
C. Enter your 2-digit county code and the amount of county tax to be withheld from each annuity or pension payment..... C. \$ _____
D. Total amount withheld: add line B plus line C (must be \$10 or more)..... D. \$ _____

I request voluntary income tax withholding from my annuity or pension payments.

Signature of Annuitant _____ Date _____

Sign and Date

Benefit Distribution Application for Retirement Benefits – Additional Benefit and/or Vesting Credit for Uniformed Service or Related Union Work

If you were a member of the Uniformed Service of the United States, fill out this portion.

If you have had any other contributions made by another Pension Fund covered by another union, fill out this portion.

ADDITIONAL BENEFIT AND/OR VESTING CREDIT

(If Applicable)

CREDIT FOR UNIFORMED SERVICE FOR THE UNITED STATES

(If you were in the Uniformed Service of the United States, please complete the following)

Under the terms of the Plan and Federal Law, you may be credited with hours of service and accrued Credit Years for the period of your service in the Armed Forces or other uniformed service for the United States, if you meet the following requirements:

1. You served in the Armed Forces or other uniformed services of the United States for five years or less, unless your service was extended by the government; and
2. You resumed work as an employee covered by this Plan within 12 months of the date of your discharge under honorable conditions, unless you were prevented from resuming employment within 12 months of discharge because of an illness or injury you incurred during or aggravated by your service in the Armed Forces or other uniformed service of the United States.

The Fund will need a copy of your "Report of Separation from the Armed Forces of the United States" (form DD-214) letter.

Date of entry _____ Date of discharge _____

RELATED UNION WORK

If you have had any contributions made on your behalf to another Pension Fund covering workers represented by the International, or any other associated union, please complete the following:

Name of Fund _____ Local Union No. _____
(Please attach separate sheet for additional Local or Fund information)

Location of Fund _____ Phone Number _____

Years in which contributions were made _____

Name of Last Contributing Employer _____

The information you provide above will be reviewed upon receipt of your application. Please be aware that there is no guarantee that you will receive additional benefit and/or vesting credit based upon this information. This could be due to any number of reasons, including, but not limited to, lack of eligibility for said credit or that such credit has already been awarded to you.

Benefit Distribution Application for Retirement Benefits – Estimate



Indiana State Council of Carpenters' Pension Fund

P.O. Box 969, Troy, MI 48099-0969
Phone: (800) 700-6756

For: _____ FILE NO: _____
Date of Retirement: _____
This statement is based on data in the Fund's records as of _____

(The amounts listed below do not include federal tax withholding or health insurance deductions.)

According to the records of the Pension Plan for the Indiana State Council of Carpenters, your estimated* Accrued Vested Benefit as of the date of this statement is \$ _____. Please initial the box to the left of the Benefit Options Type you would like to select.

The optional forms of benefit under the plan are adjusted to be actuarially equivalent to the normal form of benefit. Actuarial equivalence adjustment factors needed to determine the reduced amount are provided by the Plan actuary.

*This is an estimated amount because its accuracy is subject to the completeness of the Pension Fund Office's records, the information you provided when you requested an estimate with applications and contributions, which may subsequently be received from contributing Employers. The estimated amounts may change if the information you have supplied in your application and accompanying documents differs from that in the Pension Fund Office's records.

SINGLE LIFE BENEFIT
\$ _____

The Single Life Benefit is a non-reduced monthly benefit. Although the payments stop after death, this is the highest monthly pension amount that you can receive. Note: after your death, beneficiaries are not able to collect payments.

LIFE FIVE YEAR CERTAIN BENEFIT
\$ _____

This benefit is payable for life, but guaranteed for a certain period of 60 months. This is an adjusted monthly benefit payable to you for as long as you live with the provision that if you die before reaching 60 monthly payments, the monthly benefit would be paid to your designated beneficiary for the balance of the 60 months.

Designated Beneficiary Name: _____ SSN: _____ Relationship: _____

LIFE TEN YEAR CERTAIN BENEFIT
\$ _____

This benefit is payable for life, but guaranteed for a certain period of 120 months. This is an adjusted monthly benefit payable to you for as long as you live with the provision that if you die before reaching 120 monthly payments, the monthly benefit would be paid to your designated beneficiary for the balance of the 120 months.

Designated Beneficiary Name: _____ SSN: _____ Relationship: _____

FIFTEEN YEAR CERTAIN
\$ _____

This benefit is payable for life, but guaranteed for a certain period of 180 months. This is an adjusted monthly benefit payable to you for as long as you live with the provision that if you die before reaching 180 monthly payments, the monthly benefit would be paid to your designated beneficiary for the balance of the 180 months.

Designated Beneficiary Name: _____ SSN: _____ Relationship: _____

TWENTY YEAR CERTAIN
\$ _____

This benefit is payable for life, but guaranteed for a certain period of 240 months. This is an adjusted monthly benefit payable to you for as long as you live with the provision that if you die before reaching 240 monthly payments, the monthly benefit would be paid to your designated beneficiary for the balance of the 240 months.

Designated Beneficiary Name: _____ SSN: _____ Relationship: _____

50% JOINT & SURVIVOR
\$ _____ \$ Spouse: _____

You will receive this adjusted benefit as long as you live. Your spouse, if still living at your death, will receive a lifetime monthly benefit of one-half of the monthly benefit being paid to you at the time of your death for as long as she/he lives. Federal law requires that if you are married, your pension must be paid in the above 50% Joint & Survivor benefit.

75% JOINT & SURVIVOR
\$ _____ \$ Spouse: _____

You will receive this adjusted benefit as long as you live. Your spouse, if still living at your death, will receive a lifetime monthly benefit of three-quarters of the monthly benefit being paid to you at the time of your death for as long as she/he lives.

100% JOINT & SURVIVOR
\$ _____ \$ Spouse: _____

You will receive this adjusted benefit as long as you live. Your spouse, if still living at your death, will receive a lifetime monthly benefit equal to the monthly benefit being paid to you at the time of your death for as long as she/he lives.

The monthly benefit you elect will be taxable income and a 1099-R for income tax purposes will be issued yearly. Complete the enclosed W-4P form and return it with your signed form. The monthly benefit you elect is irrevocable and not subject to change at a later date. The benefit cannot commence until your signed option form is received by this office. PLEASE KEEP A COPY FOR YOUR RECORDS!

Member's Signature _____ Date of Signature _____

Spouse's Signature _____ Date of Signature _____

**** THIS FORM MUST BE SIGNED BY THE SPOUSE IN FRONT OF A NOTARY PUBLIC IF YOU ARE NOT CHOOSING THE 50% JOINT & SURVIVOR OPTION****

WAIVER OF 50% JOINT & SURVIVOR BENEFIT Spouse's Statement

I, _____, am the legal spouse of _____, I, _____, hereby consent to my spouse's rejection of the husband and wife pension. I understand that as a result, I will not be paid the 50% Joint & Survivor pension benefit from the pension plan after my spouse's death. I further recognize that because of this rejection the pension paid to my spouse while living will be different than it would be if I had the 50% survivor protection.

(Date) _____ (Spouse's Signature) _____

State Of _____) SS: _____
County Of _____)

On The _____ Day Of _____ 20____ before me came _____ to me known and known to me to be the person described in and who executed the foregoing statement and (s)he duly acknowledged to me that (s)he executed the same.

Notary Public _____ (Seal)
My Commission Expires _____

Selected the preferred vested benefit by initialing in the corresponding box.

If single, only the member signs.

If married, both the member and spouse must sign the form. If NOT selecting 50% Joint and Survivor benefit – this MUST be signed by member and spouse in front of a notary. Notary and Member/Spouse dates must all match.

Benefit Distribution Application for Retirement Benefits

These items must be included with every completed application:

1. Copy of member's photo ID
2. Copy of member's birth certificate
3. Certification of Martial/Single Status

If married or previously married:

1. Copy of spouse's photo ID
2. Copy of spouse's birth certificate
3. Copy of marriage certificate
4. If divorced or previously divorced, ALL divorce decrees and settlement agreements must be included.

Please do not send originals of any files, they will not be returned.

Benefit Distribution Application for Retirement Benefits

The Benefit Distribution Application is now complete. To ensure you have completed this correctly or if you have questions, please contact BeneSys for assistance –
800-700-6756

Application, form of identification, certificate of martial/single status, and if applicable, marriage certificate/divorce decrees can be sent to BeneSys via:

Fax: 248-721-9678

Email: retire@benesys.com