

**INTERNATIONAL ASSOCIATION OF HEAT AND FROST INSULATORS AND ASBESTOS  
WORKERS LOCAL UNION NO. 13 PENSION PLAN**

P. O Box 834  
Troy, MI 48099

(410) 872-9500

(410) 872-1275 Fax

**APPLICATION FOR RETIREMENT OR DISABILITY BENEFITS**

**Please print or type**

NAME (Last, First, Middle)		MARITAL STATUS (If married please complete the following questions) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Windowed <input type="checkbox"/> Divorced	
ADDRESS (Where check or correspondence should be sent)		NAME OF SPOUSE (Last, First, Middle)	
CITY, STATE, ZIP		SPOUSE SOCIAL SECURITY NUMBER	DATE OF MARRIAGE (ATTACH PROOF)
DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	SPOUSE DATE OF BIRTH (Attach Birth Certificate or other proof)

BENEFICIARY NAME (Last, First, Middle)		CONTINGENT BENEFICIARY NAME (Last, First, Middle)	
ADDRESS OF BENEFICIARY		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
RELATIONSHIP	SOCIAL SECURITY NUMBER	RELATIONSHIP	SOCIAL SECURITY NUMBER

TYPE OF RETIREMENT FOR WHICH YOU ARE APPLYING <input type="checkbox"/> Normal <input type="checkbox"/> Early <input type="checkbox"/> Late <input type="checkbox"/> Disability <small>(IF DISABILITY ATTACH COPY OF SOCIAL SECURITY AWARD LETTER)</small>			DATE FIRST EMPLOYED IN THIS JURISDICTION		
LAST DAY WORKED OR EXPECTED TO WORK (Month, Day, Year)		LAST EMPLOYER FOR WHOM YOU WORKED		I PLAN TO RETIRE ON (Month, Day, Year)	
HAVE YOU APPLIED FOR RETIREMENT BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, CHECK TYPE OF RETIREMENT YOU APPLIED FOR: <input type="checkbox"/> Normal <input type="checkbox"/> Early <input type="checkbox"/> Disability		
ARE YOU NOW OR WHERE YOU EVER A SOLE PROPRIETOR OR A PARTNER OF A COMPANY IN THIS INDUSTRY <input type="checkbox"/> YES <input type="checkbox"/> NO			LIST BELOW ANY INTERRUPTION IN YOUR EMPLOYMENT IN THE INDUSTRY DUE TO DISABILITY, MILITARY, MATERNITY OR PATERNITY LEAVE, OR WORK FOR A SIGNATORY EMPLOYER IN NON-COVERED EMPLOYMENT		
NAME & TYPE OF BUSINESS	FROM (MO/YR)	TO (MO/YR)	NAME & TYPE OF BUSINESS	FROM (MO/YR)	TO (MO/YR)
LIST OTHER LOCAL UNIONS IN THIS TRADE WHERE YOU HAVE WORKED WHOSE PENSION FUND MIGHT BE RECIPROCAL WITH THIS PENSION FUND. PLEASE INDICATE LOCAL #, STATE AND YEARS WORKED:					
IF PREVIOUSLY DIVORCED, HAS A QUALIFIED DOMESTIC RELATIONS ORDER BEEN ISSUED BY THE COURT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE FURNISH A COPY OF THE COURT ORDER					

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO CERTIFY THAT I WILL ADHERE TO THE RETIREMENT REQUIREMENTS OF THE PLAN. I UNDERSTAND A FALSE STATEMENT MAY DISQUALIFY ME FOR BENEFITS.

THIS APPLICATION REVOKES ANY PRIOR APPLICATIONS AND DESIGNATIONS OF BENEFICIARIES.

PARTICIPANT'S SIGNATURE		DATE
WITNESS SIGNATURE		DATE
LOCAL UNION NUMBER	UNION MEMBERSHIP NUMBER	