WESTERN WASHINGTON GLAZIERS PENSION TRUST

APPLICATION FOR DISABILITY RETIREMENT BENEFITS

1. Please read each question carefully.
2. Print or type all information.
3. Be sure to answer all applicable questions to avoid delay in processing your application.
4. Attach additional sheets if you need more space to answer any questions.
5. BE SURE TO SIGN AND DATE THIS APPLICATION.
6. The application must be filed prior to the first month in which your pension is to begin.
7. Mail the completed application and proof of age to the address at the bottom of this page.

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1. Name _____
   Last First Middle

   Previous Name (if any) _____ Date Changed _____

2. Social Security # _____ 3. Phone # _____

4. Mailing Address _____
   Street Number City State Zip Code

5. Local Union _____ 6. Gender: Male ☐ Female ☐ 7. Birthdate _____
   (Attach Proof of Age, see Page 2)

8. Marital Status: **Please complete the enclosed CERTIFICATION OF MARITAL STATUS.**

   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).

9. Current Spouse's Name _____
   Last First Middle

10. Spouse's Social Security # _____ Spouse's Birthdate _____

    Date of Marriage _____
    (Attach Copy of Marriage Certificate)

In accordance with the terms of the Western Washington Glaziers Retirement Plan, I hereby apply for Disability Retirement Benefits.

If you apply for Disability Benefits and do not qualify, you may convert this to an Early Retirement Application provided you are eligible for Early Retirement Benefits.

Requirements for Eligibility for Disability Retirement Benefits include meeting the definition of Total and Permanent Disability for at least six months prior to your Retirement Effective Date.

12. Name of current or most recent employer: _____

13. The last day I worked in Covered Employment was or will be on _____
Month Day Year

14. I hereby request that my retirement be effective on the first day of _____
Month Year

NOTE: Your retirement effective date cannot be before you stop work as a Glazier or before three months prior to the date this application is received in the Administrative Office. Requirements for Eligibility for Disability Retirement Benefits include meeting the definition of Total and Permanent Disability for at least six months prior to your Retirement Effective Date.

15. If determined to be eligible, I am interested in enrolling in the Retiree Medical Plan. I understand a monthly premium must be paid. YES ☐ NO ☐

16. Are you receiving benefits from any other pension plans due to your Employment as a Glazier? YES ☐ NO ☐

PLEASE READ CAREFULLY

I understand and agree that it is my responsibility to submit any and all information needed to establish my eligibility for benefits under this Plan and that this application can be cancelled by written request submitted to the Trust Office prior to its Effective Date. I certify that the information on this form is true and accurate to the best of my knowledge.

I also authorize the release of my medical records to the Administrative Agent for the purpose of determining my benefits payable under the provisions of this Plan or any other Plan. I am personally responsible for any expenses incurred in providing this information.

I understand the conditions of my retirement are governed by the Plan rules and regulations.

I understand that in the case of an overpayment of my pension benefits, the Trustees are entitled to recover any amounts overpaid to me.

If no information appears under the Spouse's Section above, I certify that I am not married.

_____ _____
Applicant's Signature Date

AGE VERIFICATION

A copy of your and your spouse's or beneficiary's birth certificates, along with proof of your marriage, is required to process your application.

IMPORTANT: If the name on either your or your spouse's or beneficiary's birth certificate is different from your present names, you must also submit a copy of the court order, marriage certificate, affidavit, or other document to show the name change(s).

If you are unable to obtain a copy of either birth certificates, you must submit TWO ITEMS of the following documents for each person who does not have a birth certificate. Please note that the documents submitted must show a birth date:

Baptismal Certificate

Citizenship or Naturalization Papers

Records or information obtained from the U.S. Census Department

Life Insurance policies taken out at least 10 years prior to your date of retirement

Social Security Information

U.S. Armed Forces Records

School records established prior to your 21st birthday

Passport

Driver License with photograph

Marriage Records showing birth date

Civil Service Records

UNION MEMBERSHIP HISTORY

Name: _____ Social Security #: _____

Please list all Union Membership beginning with your most recent or current Local and working backward to your Initiation Date. Be sure to include time spent in the military, in other areas, and out of the Industry.

Please print or type the following information:

Local Union #	City	State	From		To	
			Month	Year	Month	Year

MEDICAL QUESTIONNAIRE

1. Full Name _____
   Last First Middle
2. Social Security # _____
3. Describe your disability: _____

   _____

   _____
4. What was the cause of your disability? _____

   _____

   _____
5. What date did you become disabled? _____
6. What was your last date of employment? _____
   Month Day Year
7. Did your disabling condition cause you to cease your employment? YES ☐ NO ☐

   If Yes, briefly describe the circumstances: _____

   _____
8. Are you able to perform <u>any</u> duties or occupation covered by the last labor agreement under which you worked?

   YES ☐ NO ☐

   If Yes, describe which duties or occupation: _____
9. Have you inquired with your Union or your Employer about other employment? YES ☐ NO ☐

   If Yes, describe the results: _____

   _____
10. List all jobs or duties which you performed in this industry: _____

    _____

    _____

    _____

MEDICAL QUESTIONNAIRE*(continued)*

11. Have you received any training for any other job or duties in this Industry? YES ☐ NO ☐

    If Yes, describe the training: _____

12. Describe the last job you performed for your Employer: _____

    _____

13. Why did you leave employment with your Employer? _____

    _____

14. List all of your formal education by grade levels:

School	Grade Level	Years

15. List all technical or vocational training which you have received (Including Armed Forces Training):

School	Proficiency Achieved	Years

16. List and describe all other job-type functions or activities acquired through self-instruction, hobbies or the like: _____

    _____

17. List all other crafts, trades and professions in which you have been employed and the duties which you performed in each:

Job Description	Duties	Years

MEDICAL QUESTIONNAIRE*(continued)*

18. Are you presently capable of performing any of the jobs described above? YES ☐ NO ☐

    If No, please state why: _____

    _____

19. Have you applied for Federal Social Security Disability Benefits? YES ☐ NO ☐

    If Yes, what was the date of the application: _____

    If Yes, what is the status of your application? APPROVED ☐ DENIED ☐ PENDING ☐

    What was the date of the award or denial? _____

20. Have you been awarded or denied benefits through State Industrial or Labor and Industries?

    YES ☐ NO ☐

    If Yes, please attach copies of the award/denial form(s) or letter(s) to this Application for Disability Benefits form.

PLEASE ATTACH A COPY OF ANY DISABILITY AWARDS OR DENIALS FROM STATE OR FEDERAL AGENCIES TO THIS APPLICATION FOR DISABILITY BENEFITS FORM

21. Other information: _____

PLEASE PROVIDE COMPLETE NAME AND ADDRESS OF YOUR PHYSICIAN(S)

List all doctors or medical providers who have treated you for the condition which you consider to be disabling and the date of your last visit. Please copy this form if additional space is needed.

	Physician I Provider's Name	Address and Phone Number	Date of Last Visit
1.			
2.			
3.			
4.			
5.			
6.			