WESTERN WASHINGTON GLAZIERS PENSION TRUST

DEATH BENEFIT APPLICATION
Statement of Beneficiary

DECEDENT INFORMATION:

Name _____
Last First Middle

Previous Name (if any) _____ Date Changed _____

Mailing Address _____
Street Number City State Zip Code

Social Security # _____ Birth Date _____

Local Union _____ Gender: Male ☐ Female ☐ Death Date _____

Marital Status: Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐

Was the Decedent retired and receiving a monthly Retirement Benefit from the Western Washington Glaziers Retirement Plan? YES ☐ NO ☐

BENEFICIARY INFORMATION:

Name _____
Last First Middle

Previous Name (if any) _____ Date Changed _____

Social Security # _____ Phone # _____

Mailing Address _____
Street Number City State Zip Code

Birth Date _____ Relationship to Decedent _____

PLEASE SUBMIT PHOTOCOPIES OF THE MEMBER'S BIRTH CERTIFICATE, YOUR BIRTH CERTIFICATE, YOUR PHOTO ID WITH SIGNATURE AND A COPY OF THE MEMBER'S DEATH CERTIFICATE.

5200 Southcenter Blvd, Suite 205, Tukwila, WA 98188 • P O Box 58830 • Tukwila, WA 98138
Phone (206) 518-9730 • Toll Free (844) 344-2721 • Fax (425) 251-1976
www.IUPATWesternBenefits.org

WESTERN WASHINGTON GLAZIERS PENSION TRUST

I certify and attest that I am the lawful Beneficiary of:

Decedent's Name _____
Last First Middle

In accordance with the Western Washington Glaziers Retirement Plan, I hereby request payment of the Death Benefits to myself as the Beneficiary of the above-named deceased.

I understand and agree that it is my responsibility to submit any and all information needed to establish my eligibility for receipt of Beneficiary Death Benefits under the Western Washington Glaziers Retirement Plan.

I have received a copy of the booklet containing the provisions of the Pension Plan of the Western Washington Glaziers Retirement Plan and understand the conditions of my retirement are governed by that Plan as it may be amended from time to time.

_____ _____
Applicant's Signature Date

Subscribed and sworn to before me this _____ day of _____ , 20_____

_____ , Notary Public in and for the State of _____

residing in _____. My commission expires on _____

WESTERN WASHINGTON GLAZIERS PENSION TRUST

Western Washington Glaziers Retirement Plan

ELECTION REGARDING DISTRIBUTION OF FUNDS ELIGIBLE FOR ROLLOVER

PLEASE READ THE ENCLOSED SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS CAREFULLY BEFORE MAKING AN ELECTION. Check Option A if you wish to execute a DIRECT ROLLOVER to a qualified retirement plan. If you select Option A, you must also complete the reverse side of this form. Check Option B if you want your distribution to be PAID TO YOU.
If you do not elect to have your distribution transferred to another qualified retirement plan, you may be liable for payment of Federal Income Tax on your lump sum pension payment. You may also be subject to an excise tax on premature distributions. Consult your tax advisor or the Internal Revenue Service for further information.

_____ A - DIRECT ROLLOVER: I want to have my payment(s) issued to a qualified retirement plan or IRA. PLEASE ISSUE MY CHECK(S) PAYABLE TO:

PAYEE:

_____

If you select Option A you must also complete page 4.

_____ B - PAID TO YOU: I DO NOT wish to have my payment(s) issued to a qualified retirement plan. Please issue my payments(s) directly to me. I UNDERSTAND THAT MY PAYMENT(S) WILL BE SUBJECT TO MANDATORY FEDERAL INCOME TAX WITHHOLDING IN THE AMOUNT OF 20% OF THE TOTAL DISTRIBUTION. IF YOU WOULD LIKE ADDITIONAL WITHHOLDING PLEASE COMPLETE THE W4R FORM.

By signing below, I certify that I have read and understand the information provided on the attached SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS.

_____ _____
Beneficiary Name (Please Print) Social Security Number

_____ _____
Beneficiary Signature Date

WESTERN WASHINGTON GLAZIERS PENSION TRUST

REQUEST AND AUTHORIZATION TO EXECUTE A DIRECT ROLLOVER

I hereby request and authorize the said trust to make payable my pension payment(s) to the below named Trust or Financial Institution for deposit into my account number_____.

_____ _____
Name (Please Print) Social Security Number

_____
Mailing Address

_____
City, State, Zip

_____ _____
Beneficiary Signature Telephone Number

THE BOTTOM HALF OF THIS FORM MUST BE COMPLETED BY A REPRESENTATIVE OF THE RECEIVING TRUST OR FINANCIAL INSTITUTION

The terms of the request and authorization above under which payments are to be made by the Trust Fund to this Trust or Financial Institution are noted and accepted by this Trust or Financial Institution. The below named Trust is an IRA, Code Section 403(a) Annuity Plan or Qualified Defined Contribution Plan that accepts rollover contributions.

Dated this _____ day of _____ 20 _____

_____
Check(s) to Made Payable to (Name of Receiving Trust or Financial Institution)

_____
Mailing Address

_____
City, State, Zip

_____ _____
Signature of Authorized Officer Telephone Number