RHODE ISLAND CARPENTERS BENEFIT FUNDS

APPLICATION FOR NORMAL, SERVICE OR EARLY RETIREMENT BENEFITS

CHECKLIST OF ITEMS TO SUBMIT WITH YOUR BENEFIT APPLICATION:

Please utilize the checklist below to ensure that you have completed your application fully. This will expedite the application process. Missing documents and incomplete application forms will delay the processing of your application. Items that are in **bold** MUST be signed in front of a Notary Public (date of both signatures must match).

- ❑ **Retirement Declaration Form**
- ❑ **Application Form**
- ❑ **Pension Benefit Option Election Form, including the**
- ❑ **Waiver of 50% J&S (if applicable)**
- ❑ **Life-Ten Year Certain Guarantee Form**
- ❑ Additional Benefit and/or Vesting Credit (if applicable)
- ❑ **Waiver of 30-Day Notice (married only)**
- ❑ **Certification of Marital/Single Status**
- ❑ Acknowledgement of Early Retirement Supplemental (if applicable)
- ❑ Statement of Application Receipt (married only)
- ❑ Withholding Certificate for Pension or Annuity Payments, *IRS Form W-4P*
- ❑ Direct Deposit Agreement (optional)
- ❑ Copy of your birth certificate
- ❑ Copy of your spouse's birth certificate
- ❑ Copy of your marriage license
- ❑ Copy of your photo ID
- ❑ Copy of your spouse's photo ID
- ❑ Copy of any and all previous divorce decrees, Qualified Domestic Relations Orders, Separation Agreements, 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.

RHODE ISLAND CARPENTERS BENEFIT FUNDS

APPLICATION FOR NORMAL, SERVICE OR EARLY RETIREMENT BENEFITS

Retirement Declaration

Name _____ Social Security No._____

I am retiring on a pension from the Rhode Island Carpenters Pension Plan. I declare that I will be bound by all the rules and regulations of the Pension Plan.

I understand that if a retiree has reached Normal Retirement Age (generally age 62), and works for 40 or more hours in any month in the same trade or craft, same industry and the same geographic area covered by the Plan, his pension will be suspended. This work is known as Disqualifying Employment.

I understand that a retiree who has not yet reached Normal Retirement Age (generally age 62) will have his pension suspended due to Disqualifying Employment for any month in which he undertakes employment in any of the following:

(a) ***Employment with any contributing Employer;***

(b) ***Employment with any employer in the same or related business as any contributing Employer;***

(c) ***Self Employment in the same or related business as any contributing Employer;***

(d) ***Employment or Self Employment in any business which is or may be under the jurisdiction of the Union or of any local union of the United Brotherhood of Carpenters and Joiners of America.***

I further understand that if I return to work before Normal Retirement Age, I will be subject to an additional six-month suspension once I cease working, but not beyond my Normal Retirement Age. If I am receiving a Service Pension and I return to work as described above, my benefit will be suspended for an additional twelve months once I cease working, but not beyond my Normal Retirement Age.

I agree to notify the Fund Office within 21 days of commencing work that may be Disqualifying Employment.

I agree that I must furnish any information requested by the Trustees concerning my employment and that I have the right to appeal a suspension under the Plan's appeals procedures.

I understand I will be required to reimburse the Pension Fund for all pension benefits I have accepted in violation of the rules of the Pension Plan.

_____ _____

(Signature of Pensioner) *(Date)*

RHODE ISLAND CARPENTERS BENEFIT FUNDS

APPLICATION FOR NORMAL, SERVICE OR EARLY RETIREMENT BENEFITS

TO: Board of Trustees
14 Jefferson Park Road • Warwick, RI 02888
Phone (401) 467-6813 • Fax (401) 467-6816

I hereby apply, under the Plan of the RHODE ISLAND CARPENTERS PENSION FUND, for:

☐ **Normal Retirement Benefits**

☐ **Early Retirement Benefits**

☐ **Deferred Vested Retirement Benefits**

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

Please note, this application will be valid only if returned to the Fund Office within 90 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.

(Please type or print):

Participant Information:

Name _____

Date of Birth _____ Social Security No. _____

Full Address _____
(Street) (City) (State) (Zip)

Home Phone Number _____ Alternate Phone Number _____

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

I am (check all that apply) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Information:

Name _____

Social Security Number _____ Date of Birth _____

CERTIFICATION OF MARITAL/SINGLE STATUS

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)*
- ☐ LEGALLY SEPARATED*
- ☐ 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):

Ex-spouse's Name	Date of Marriage	Date of Divorce/Death

Please provide complete copies of ALL marriage certificates, 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 BENEFITCOMMITS 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 Representatives 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 OPTION ELECTION FORM

Participant Name _____ Participant Soc. Sec. # _____

I hereby acknowledge that I understand my rights to benefits from the Rhode Island Carpenters Pension Fund. I hereby elect to receive my monthly benefits in the form indicated below. **I understand that, if I am married on my effective date, I will receive my benefits in the 50% Joint and Survivor form UNLESS I elect another form of benefit and, if I wish to elect to receive benefits in the Single Life or Life-Ten Year Certain form, my spouse consents to my waiver of the 50% Joint and Survivor form by signing the Spousal Consent to Waiver of 50% Joint and Survivor Form.**

- ❑ **50% Joint and Survivor form**
  - ❑ **Spouse** ☐ **Beneficiary** _____ **please provide address below**
- ❑ **66 2/3% Joint and Survivor form**
  - ❑ **Spouse** ☐ **Beneficiary** _____ **please provide address below**
- ❑ **75% Joint and Survivor form**
  - ❑ **Spouse** ☐ **Beneficiary** _____ **please provide address below**
- ❑ **100% Joint and Survivor form**
  - ❑ **Spouse** ☐ **Beneficiary** _____ **please provide address below**
- ❑ **Single Life form**

❑ **Ten-Year Certain form, under which I designate** _____,
(Name)

My _____, to be my beneficiary.
(Relationship)

Beneficiary's address: _____
(Street)

_____
(City) (State) (Zip)

Beneficiary's Social Security Number: _____

❑ For multiple beneficiaries, an additional form is necessary, contact the Fund Office.

ELECTION TO WAIVE JOINT AND SURVIVOR FORM OF BENEFIT

I, _____, hereby acknowledge that I have been informed that the normal form of benefits payable to me is the 50% Joint and Survivor form. I understand that I have the right to waive that form and elect a 66 2/3%, 75%, or 100% Joint and Survivor form of benefit or, provided that my spouse consents in writing to both the waiver and the election, waive the 50% Joint and Survivor form and elect a Single Life or a Ten-Year Certain form of benefit. I understand the financial effect of waiver of the 50% Joint and Survivor form (an estimate of which has been calculated and explained to me), and I understand that (1) if I elect the Single Life form of benefit, no further benefits will be payable from the Fund to my surviving spouse after my death; (2) I may revoke this or any waiver prior to my effective date; and (3) after the effective date of my retirement, my waiver is irrevocable.

❑ I elect to waive the 50% Joint and Survivor form of pension payment.

Participant Signature _____ Today's Date _____

Place Notary Stamp/Seal
Or
Authorized Fund Representatives 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.**

SPOUSAL CONSENT TO WAIVER OF 50% JOINT AND SURVIVOR FORM (REQUIRED FOR ELECTION OF SINGLE LIFE OR TEN-YEAR CERTAIN FORM)

DO NOT SIGN AND DATE THIS FORM UNLESS YOU ARE IN THE PRESENCE OF A NOTARY PUBLIC

I am the legal spouse of _____. I acknowledge that I have been informed that my spouse wishes to reject the normal form of benefit (the 50% Joint and Survivor form) and, instead, elect a form of benefit under the Rhode Island Carpenters Pension Fund other than another Joint and Survivor form. I hereby consent to the election of my spouse to waive the 50% Joint and Survivor form of benefit, and I acknowledge and understand that (1) my spouse cannot waive my right to be protected under the 50% Joint and Survivor form of benefit unless I consent to my spouse's waiver by signing this form in the presence of either an authorized representative of the Fund or a Notary Public; (2) if my spouse elects the Single Life form, I will not receive any benefits from the Rhode Island Carpenters Pension Fund after my spouse's death, and (3) after the effective date of my spouse's retirement, my consent is irrevocable.

If the Joint and Survivor form is waived and the Single Life form is elected, the surviving spouse will not receive any monthly pension upon the death of the Participant.

_____ _____

Spouse's Signature . Today's Date

Place Notary Stamp/Seal
Or
Authorized Fund Representatives 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.

REQUIRED FOR ELECTION OF LIFE-TEN YEAR GUARANTEE FORM
(To be completed only if spouse is not named as beneficiary)

DO NOT SIGN AND DATE THIS FORM UNLESS YOU ARE IN THE PRESENCE OF A NOTARY PUBLIC

With my consent, my spouse has elected to receive benefits in the Ten-Year Certain form and to designate _____ as beneficiary. I hereby consent to that designation of beneficiary.

_____ _____

Spouse's Signature Today's Date

Place Notary Stamp/Seal
Or
Authorized Fund Representatives Signature Here

Subscribed to and sworn to before me,
This _____ day of _____.

_____
(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.

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 % Joint and Survivor form, including my right to waive that 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 Participant Signature

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 % Joint and Survivor form, including my spouse's right to waive the 50% Joint and Survivor 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

_____ _____

Your Signature . Today's Date

Place Notary Stamp/Seal
Or
Authorized Fund Representatives 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.**

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 the time limits (reference ***** below) required by the law from the date of your discharge under honorable conditions, unless you were prevented from resuming employment within those time frames 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.

***For service of:**
31-180 days, you have 14 days to return
> 180 days, you have 90 days to return
< 31 days, 1st day of next work period

APPRENTICESHIP

(If Applicable)

Period of time attended: _____

Employer (s) : _____

Local # (s) : _____

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)

NOTIFICATION OF APPLICATION RECEIPT

(All participants must complete)

☐ Please notify me by email that my application has been received.

_____

(Please print email address)

☐ Please contact me in writing that my application has been received.

Place Notary Stamp/Seal Here
Authorized Plan Representative or Notary Public

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

Notary Public, _____ County

State of _____

My Commission expires _____

***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.**