# ROOFERS LOCAL NO. 2 SUPPLEMENTAL PENSION PLAN

PO Box 1458, Maryland Heights, MO 63043
Toll-Free (877) 463-0835 Local (314) 656-1090 Fax (314) 338-3212

## APPLICATION FOR BENEFITS

**SECTION I - PERSONAL INFORMATION**

Participant's Name_____
Last First Middle Initial

Social Security No._____

Birthdate_____ *(Attach Copy of Birth Certificate, Driver's License, and Social Security Card)*

Address_____
Number and Street City State Zip Code

Telephone No. (_____)_____

**********

Spouse's Name_____
Last First Middle Initial

*(If you are not married, write "None" on the line above)*

Spouse's Social Security No._____

Spouse's Birthdate_____ *(Attach Copy of Birth Certificate, Driver's License, Marriage License, and Social Security Card)*

Spouse's Telephone No. (if different) (_____)_____

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Social Security Number of Decedent:_____(If applying for Death Benefit)

Name of Decedent:_____(If applying for Death Benefit)

## SECTION II - TYPE OF BENEFIT (Choose One Option)

☐ **EARLY RETIREMENT** *(Age 55-64 and no longer working in Covered Employment)* ***Must attach proof of retirement (e.g. award letter from Social Security or letter from employer)***
Date of Retirement _____

☐ **NORMAL RETIREMENT** *(Age 65+ and no longer working in Covered Employment)* ***Must attach proof of retirement (e.g. award letter from Social Security or letter from employer)***
Date of Retirement _____

☐ **TERMINATION** *(3 Year Break in Service and no employment anywhere in the roofing trade or as a supervisor in the roofing trade)* ***Must attach last 3 years of tax returns and W-2s. If married and you file your taxes jointly, you must also include your spouse's W-2s***

I attest that I have not worked in employment anywhere in the roofing trade or as a supervisor inthe roofing trade since_____.

☐ **DEATH** *(Attach a Certified copy of Participant's death certificate. The person applying for the death benefit must provide a copy of their birth certificate, driver's license, and Social Security card. Further, the surviving spouse must provide a copy of their marriage license. If applicable, the Dependent Survivor Affidavit must be completed)*

☐ **DISABILITY** *(Attach Social Security Disability Award letter or NRIPP Disability Award letter)*

☐ **QUALIFIED DOMESTIC RELATIONS ORDER** *(Attach a copy of the alternate payee's birth certificate, driver's license, and Social Security card)*

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## SECTION III - PARTICIPANT'S CERTIFICATION IF NO SPOUSE (Must Check One Box)

☐ I hereby certify that I am not now married and that there are no Plan benefits payable to a former spouse under a Qualified Domestic Relations Order and/or Divorce Decree.

☐ I hereby certify that I am not now married; however, there may be a reduction in my benefits as a result of a Qualified Domestic Relations Order and/or Divorce Decree.

_____

Signature of Participant Date Signed

## SECTION IV – FORM OF PAYMENT (Choose One Option)

Below is an explanation of each of the different payment options available under the Plan. Please read the explanations carefully and contact the Fund Office if you have any questions. In addition, please read the attached *Special Tax Notice Regarding Plan Payments* for important information on the tax consequences of your election before you elect one of the following:

☐ **One Lump Sum Payment.** If you check this box, your entire account balance will be paid directly to you in a single lump sum payment. No benefits will be payable to your spouse or your beneficiary upon your death. (Taxes will be withheld as required by Federal law). If you are married, both you and your spouse must complete Section VI to elect this form of payment.

☐ **Direct Rollover.** (No taxes will be withheld). The amount you elect to roll over will be sent directly to the IRA or other qualified pension plan you identify. If you check this box, you must furnish the Fund Office with a letter from the IRA or other qualified pension plan, authorizing this Plan to make a Direct Rollover. By checking this box, you are also representing that the trusteeor plan that is to receive the Direct Rollover is an IRA or pension plan that is qualified to accept a rollover. Please provide the following information:

NAME OF PLAN:_____

ACCOUNT NUMBER:_____

NAME OF INSTITUTION:_____

ADDRESS:_____

_____

If you want a partial Direct Rollover, check this box ☐ and fill in the amount of your Plan benefit that is to be rolled over: $_____. The remainder of your Plan benefit will be paid directly to you, and taxes will be withheld as required by Federal law on the portion that is paid directly to you.

☐ **Single Life Annuity. (Non-married participants will receive their benefit in this form, unless another form of payment is elected).** Monthly payments will be made to you for the balance of your life. All benefit payments stop when you die. If you are married, you and your spouse must complete Section VI to elect this form of payment. If you are married and elect this form of payment, your spouse will not receive any benefit payment(s) after your death.

☐ **Qualified Joint and 50% Survivor Annuity. (Married participants will receive their benefit in this form with their spouse receiving the survivor annuity upon their death, unless another form of payment or another beneficiary is elected with the spouse's consent where required)** Monthly payments will be made to you for the balance of your life. Upon your death, if your spouse or other named beneficiary survives you, your spouse or other beneficiary will receive monthly payments of 50% of the amount you had been receiving. If you are married and you want someone other than your spouse to receivethe survivor annuity upon your death, both you and your spouse must complete Section VI.

☐ **Qualified Joint and 75% Survivor Annuity.** Monthly payments will be made to you for the balance of your life. Upon your death, if your spouse or other named beneficiary survives you, your spouse or other beneficiary will receive monthly payments of 75% of the amount you had been receiving. If you are married and you want someone other than your spouse to receive the survivor annuity upon your death, both you and your spouse must complete Section VI.

☐ **Qualified Joint and 100% Survivor Annuity.** Monthly payments will be made to you for the balance of your life. Upon your death, if your spouse or other named beneficiary survives you, your spouse or other beneficiary will receive monthly payments of 100% of the amount you had been receiving. If you are married and you want someone other than your spouse to receive the survivor annuity upon your death, both you and your spouse must complete Section VI.

☐ **Installment Payments.** Your account balance will be paid to you in equal monthly or annual amounts over a period you elect. Once all of your annual/monthly installments have been paid, no further benefits will be paid to you or any spouse or beneficiary. If you die before the entire balance of your account has been paid to you, the remaining balance in your account will be paid to your spouse or named beneficiary. If you are married, both you and your spouse must complete Section VI to elect this form of payment. Please select one:

☐ Annual Installments over__(enter number) of years

☐ Monthly Installments over_(enter number) of months

If the number of installments you select is greater than permitted by law, the Fund will reduce the number of installments so that your benefit is paid to you in accordance with the requirements established by law.

☐ **Combination of Lump Sum Payment and Installment Payments.** Your account balance will be paid to you in a partial lump sum payment, with the remainder paid out in installments over a period you elect. Once all of your annual/monthly installments have been paid, no further benefits will be paid to you or any spouse or beneficiary. If you die before the entire balance of your account has been paid to you, the remaining balance in your account will be paid to your spouse or named beneficiary. If you are married, both you and your spouse must complete Section VI to elect this form of payment. Please complete:

-Partial Lump Sum Amount: $_____(enter amount you want to receive in a lump sum)

-Remainder to be paid in (select one):

☐ Annual Installments over_____(enter number) of years

☐ Monthly Installments over_____(enter number) of months

If the number of installments you select is greater than permitted by law, the Fund will reduce the number of installments so that your benefit is

☐ **Partial Lump Sum Payment.** Your account balance will be paid to you in a partial lump sum payment, with the remainder to remain invested (taxes will be withheld according to Federal law). Please complete:

- Partial Lump Sum Amount: $_____(enter amount you want to receive in a lump sum; the remainder will remain invested)

**The Roofers Local No. 2 Supplemental Pension Plan may provide benefits through the purchase of any appropriate annuity contract or contracts from an insurance company for single life annuities and qualified joint and survivor annuities. Any fees, commissions or other costs directly incurred in connection with the purchase of any annuity may be deducted from your Individual Account balance immediately before purchase. The amount of your monthly benefit will be different depending on the type of annuity you elect. For example, electing a qualified joint and survivor annuity over a single life annuity will likely result in a lower monthly payment to you because the benefit will be payable over a longer period of time.**

Must be completed if you selected a Qualified Joint and Survivor Annuity or Installment payments and you want someone other than your spouse to be your beneficiary.

## SECTION V – ALTERNATE BENEFICIARY DESIGNATION

YOU DO NOT NEED TO COMPLETE THIS SECTION IF YOU WANT YOUR SPOUSE TO BE YOUR BENEFICIARY

If you elected to receive your benefit in the form of a Qualified Joint and Survivor Annuity and you want someone other than your spouse to receive the survivor annuity, or if you elected to receive your benefit in installment payments and want someone other than your spouse to receive the remaining benefit if you die before all payments have been made, please complete this section. If you are married, you and your spouse will need to complete Section VI.

**Beneficiary Information**:

Name_____
Last First Middle Initial

Social Security No._____

Birthdate_____ *(Attach Copy of Birth Certificate, Driver's License, and Social Security Card – if available)*

Address_____
Number and Street City State Zip Code

Telephone No. (_____)_____

Must be completed & notarized to be effective, otherwise benefits will be paid as a Qualified Joint and 50% Survivor Annuity with your spouse.

## SECTION VI - WAIVER OF QUALIFIED JOINT AND SURVIVOR ANNUITY FORM OF BENEFIT

### Participant Waiver

I hereby elect not to receive my benefit in the form of a Qualified Joint and Survivor Annuity with my spouse receiving the survivor annuity as my beneficiary. I request and direct the Roofers Local No. 2 Supplemental Pension Plan ("Fund") to pay the benefits due me in the form of payment I elected in Section IV above. Furthermore, to the extent I have completed Section V above and designated a beneficiary other than my spouse to receive any survivor benefits payable under the form of payment I elected, I request and direct the Fund to pay the survivor benefits to the beneficiary I named in Section V above, instead of my spouse. I understand that a Qualified Joint and Survivor Annuity with my spouse as my beneficiary would have allowed my spouse to continue to receive a monthly benefit for the remainder of his/her lifetime following my death, but based on my election, no benefits will be paid to my spouse upon my death. I understand that my spouse must consent to my election by completing the Spousal Consent on the next page.

I understand that I cannot change the form of payment elected in Section IV and/or the beneficiary identified in Section V without my spouse's written consent, unless I elect to change the form of payment to a Qualified Joint and Survivor Annuity with my spouse as my beneficiary.

**I understand that under federal law, the Fund must wait until at least 30 days have passed since I received the explanation of payment options contained in this Application for Benefits before benefit payments may begin; however, I do not want to wait 30 days and the Fund's 7-day election revocation period gives me and my spouse sufficient time to make an informed decision; thus, I hereby waive the 30- day waiting period and agree not to challenge the validity of my election once benefit payments begin.**

I understand that I have the right to revoke my election not to receive a Qualified Joint and Survivor Annuity with my spouse receiving the survivor annuity as my beneficiary. I understand that in order to revoke my election, my revocation must be received by the Fund no later than: (1) seven (7) days following my receipt of this Application for Benefits, or (2) the date my benefit payment(s) begin, whichever is later. In the event I timely revoke my election, I understand that my benefit will be paid in the form of a Qualified Joint and 50% Survivor Annuity with my spouse receiving the survivor annuity as my beneficiary.

_____

Signature of Participant Date Signed

## Spousal Consent

I am the lawful spouse of the Participant named above. I have read this Application for Benefits which contains an explanation of payment options and the Special Tax notice. I understand that I have the right to a survivor's annuity under the Qualified Joint and 50% Survivor's Annuity option, which would provide me with a monthly benefit for the remainder of my life following the Participant's death. I understand that by signing this document, I am waiving my right to a survivor's annuity under the Qualified Joint and 50% Survivor's Annuity option, and I am consenting to the Participant's election set out in Section IV above and/or the alternate beneficiary the Participant named in Section V above. I understand that by executing this Spousal Consent, I will not receive a monthly benefit upon the death of the Participant.

I understand that I do not have the right to revoke my consent once it has been given.

**I understand that under federal law, the Fund must wait until at least 30 days have passed since the Participant received the explanation of payment options contained in this Application for Benefits before benefit payments may begin; however, I do not want to wait 30 days and the Fund's 7-day election revocation period gives me and the Participant sufficient time to make an informed decision; thus, I hereby waive the 30-day waiting period and agree not to challenge the validity of the Participant's election.**

I understand that I am not required to give this consent and that if I do not, the Participant's election will not be effective. With this understanding, I hereby consent to the Participant's election and/or alternate beneficiary designation in Section IV and/or V of this form.

_____

Signature of Participant's Spouse Date Signed

On_____day of_____in the year_____, the Participant's Spouse designated above appeared before me and executed the above Spousal Consent as his/her free and voluntary act.

_____ _____

Signature of Notary Public Printed Name of Notary Public

Residing in_____County, in the State of_____.

My commission expires_____.

## SECTION VII - PARTICIPANT'S STATEMENT

I understand that information on the different payment options available to me, lump sums, direct rollovers, and any applicable mandatory tax withholding are described in this Application for Benefits and the Special Tax Notice Regarding Plan Payments, which I have received and reviewed. I represent that the direct rollover I am electing, if applicable, is being made to an Individual Retirement Account or a Qualified Retirement Plan.

I understand that I have the right to defer receipt of my distribution and leave my account balance in the Fund if I have not yet reached my Required Beginning Date. I understand that by taking my distribution, some currently available investment options in the Fund may not be available on similar terms outside the Fund and fees and expenses (including administrative or investment-related fees) outside the Fund may be different from those applicable to me while a participant in the Fund. I understand that I can contact the Fund Office if I have any questions regarding the Fund's investment options/fees/expenses.

By signing and dating below, I affirm that I have received the "Special Tax Notice Regarding Plan Payments" and direct that my distribution be made as soon as administratively possible.

The statements contained in this Application are true to the best of my knowledge and belief. I understand that a false statement contained in this Application or any supporting documentation may disqualify me for benefits, and the Fund may recover any payments made because ofa false statement. I agree to indemnify the Fund for any damages it incurs as a result of any false statement contained herein.

_____

Signature of Participant Date Signed

Must be completed and notarized to waive Qualified Joint and Survivor Annuity without spousal consent.

## Affidavit Regarding Marital Status

STATE OF )
) ss.
COUNTY OF_____)

I,_____, am a Participant in the Roofers Local No. 2 Supplemental Pension Plan. I do not wish to receive my pension benefits in the Qualified Joint and 50% Survivor Annuity form of payment. I make this Affidavit for the purpose of establishing that I may waive the Qualified Joint and 50% Survivor Annuity form of benefit payment without the consent of my spouse, if any. In that regard, I swear or affirm that the requirement that my spouse consent to my waiver of the Qualified Joint and 50% Survivor Annuity form of benefit does not apply because (**check all that apply**):

☐ I am not now married.

☐ I have never been married.

☐ My spouse cannot be located.

☐ My spouse and I are legally separated. A copy of the court order of separation is attached.

☐ My spouse has abandoned me. A copy of the court order of abandonment is attached.

☐ A Qualified Domestic Relations Order and/or a Qualified Medical Child Support Order, providing for all or a portion of my benefits from the Roofers Local No. 2 Supplemental Pension Plan to be paid to an Alternate Payee or beneficiary does not exist.

**Ex-spouse information (please list all ex-spouses and include copies of divorce decrees and/or death certificates):**

Name: _____ Date of birth: _____ SSN: _____

Date of Marriage: _____ Date of divorce: _____

Name: _____ Date of birth: _____ SSN: _____

Date of Marriage: _____ Date of divorce: _____

Regarding the above, I agree to indemnify and save harmless the Plan and its Trustees from any and all liability for payment of benefits upon a claim of any person who is or may be found to be my spouse.

_____
Participant's Signature

Subscribed and sworn to before me this_____day of_____, 20____.

_____
Notary Public

_____County, _____

My Commission Expires:_____

Must be completed & notarized if you selected 'Early Retirement.'

## EARLY RETIREMENT STATEMENT

By signing and dating below, I affirm that I am at least 55 years of age and have ceased all work of a type covered by any collective bargaining agreement currently in effect between the St. Louis, Missouri area roofing contractors and Roofers Local #2, and have requested that the Roofers Local #2 remove my name from the out-of-work list as I am retired. I further affirm that I have no current intentions of returning to work of a type covered by any collective bargaining agreement currently in effect between the St. Louis, Missouri area roofing contractors and Roofers Local #2.

The statements contained in this Application are true to the best of my knowledge and belief. I understand that a false statement may disqualify me to receive any payments made because of a false statement. I further understand that I will be obligated to repay any payments made to me due to a false statement. I also agree to indemnify the Roofers Local #2 Supplemental Pension Plan ("Fund") for any liability the Fund incurs as a result of any false statement knowingly made herein.

_____

Signature of Participant Date Signed

On_____day of_____in the year_____, the Participant designated above appeared before me and executed the above Early Retirement Statement as his/her free and voluntary act.

_____ _____

Signature of Notary Public Printed Name of Notary Public

Residing in_____County, in the State of_____.

My commission expires_____.