

Hotel and Restaurant Employees Health and Welfare Trust Fund
East Bay Restaurant and Tavern Retirement Plan
1182 Market Street, Suite 320 • San Francisco • California • 94102-4919
Telephone: (844) 492-9159

INSTRUCTIONS TO COMPLETE APPLICATION PACKET FOR BENEFITS

Enclosed is the application for Benefits, which must be completed to apply for benefits from the above plan. Please read the following instructions carefully. **FAILURE TO SUBMIT A COMPLETE APPLICATION MAY RESULT IN A DELAY IN THE PROCESSING OF YOUR APPLICATION.**

PAGE 2 - Application for Benefits (Required for all applicants).

PAGE 3 - Acknowledgment and Election Form (Required for all applicants).

PAGE 4 - Benefits Election Form (Required for all applicants).

PAGE 5 - Election for California State Income Tax Withholding (Required for all applicants).

PAGE 6 - Spousal Consent to Participant's Election (Required for married participants)

PAGE 7 - Statement for Non-Married Participants

PAGE 8 - Certification of Terminated Status (Required for all applicants).

PAGE 9 - Instructions for Proof of Age

REQUIRED DOCUMENTS WHICH MUST BE SUBMITTED WITH APPLICATION:

You must submit proof of age in accordance with attached instructions.
If you are married you must submit proof of age for your spouse and Marriage Certificate.

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RETURN COMPLETED APPLICATIONS TO:

EAST BAY RESTAURANT AND TAVERN RETIREMENT FUND
P.O. BOX 555
SAN RAMON, CA 94583

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APPLICATION FOR BENEFITS

Name: _____ Soc. Sec. No.: _____
Address: _____ Telephone No.: _____
_____ Date of Birth: _____
_____ (Attach proof of age)
Last Employer: _____ Last day Worked: _____
Union Initiation Date: _____ Retirement effective date: _____

Marital Status

_____ Married (enclosed copy of Marriage Certificate and spouse's proof of age)
Spouse's Name _____ SSN: _____ D.O.B. _____
_____ Never Been Married
_____ Divorced- Date of Divorce: _____ (enclosed complete copy of Divorce Decree)
_____ Widowed- Date of Death: _____ (enclosed copy of spouse's death certificate)
_____ Other-Explain _____

.....
Beneficiary Designation

Name _____ Soc. Sec. No.: _____
Address: _____
Relationship _____ Beneficiary's Signature _____

.....
Type of Benefit Applied For

_____ Normal Retirement Benefit (age 65 and over) _____ Termination
_____ Early Retirement (age 55 to age 65) _____ Disability

I hereby apply for benefits from the Hotel and Restaurant Employees Retirement Plan and declare that I will be bound by all rules and regulations of the Plan. I certify that the above statements are true and correct and understand that a false statement may disqualify me for benefits. I agree to notify the Administration Office if I return to work in covered employment and I understand that benefits may be suspended during that time.

Signature _____ Date: _____

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ACKNOWLEDGMENT AND ELECTION FORM

I hereby acknowledge that I have received the Special Tax Notice Regarding plan payments advising me of the mandatory 20% Federal Income Tax withholding requirements and my direct roll over options. I elect the option marked below:

.....
CHOOSE ONE:

_____ I ELECT TO RECEIVE THE BENEFIT AMOUNT PAYABLE AND I UNDERSTAND THE AMOUNT IS SUBJECT TO 20% MANDATORY FEDERAL INCOME TAX WITHHOLDING

_____ I ELECT A DIRECT ROLLOVER AS INDICATED BELOW:

I elect to have a direct roll over of _____ (insert the amount to be rolled over in \$ or %)

I elect to receive _____ (insert portion to be received – not rolled over in \$ or %)

(Any amount received will be subject to mandatory Federal Income Tax Withholding.)

Complete the Following if the Roll Over is to an IRA:

Name of IRA: _____
Address of IRA firm: _____
Account Number: _____
Account Name: _____
Contact Firm: _____
Telephone Number: _____

Complete the Following if the Roll Over is to another Qualified Plan:

Name of Plan: _____
Plan Sponsor: _____
Plan Tax ID No. _____
Plan's Address: _____
Telephone Number: _____

I represent that the foregoing information is correct and, if selecting a direct rollover that the IRA or other qualified Plan is eligible for and will accept a direct roll over.

Applicant's Name (Please Print)

Social Security Number

Signature

Date

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BENEFITS ELECTION FORM

I hereby elect the following form of retirement benefit: (Choose one X)

 1. JOINT & 50% TO SPOUSE PENSION

Provides reduced benefit for the lifetime of the pensioner, and after his or her death, the spouse will receive an amount equal to one half the amount paid to the pensioner for the lifetime of the spouse.

 2. LUMP SUM PAYMENT or ROLLOVER

One time lump sum payment – provided your spouse waives the joint pension

If the present value of your benefits is \$5,000.00 or less, the Trustees will distribute such amount to you in one lump sum, regardless of your request for an alternative benefit option (if the distribution is made prior your attainment of retirement age).

 3. FIXED PERIODIC PAYMENTS

Periodic payments of substantially equal amounts for a specified number of years not to exceed Fifteen (15) provided your spouse waives the Joint Pension.

If death occurs before you receive your entire amount, the balance will be paid to your spouse or designated beneficiary.

Number of year's requested: _____

 4. ANNUITY

An annuity contract purchased from a licensed insurance company providing annuity payments payable at least annually in substantially equal installments, over a period of time no longer than your lifetime, or over a period not extending beyond your life expectancy and that of your designated beneficiary.

Name of Beneficiary: _____ SS# _____

Relationship: _____ Date of Birth _____

 5. 75% Qualified Optional Survivor Annuity

This benefit form shall provide a benefit for the life of the participant with a survivor annuity for the life of the spouse which is equal to 75% of the amount of the participants lifetime benefit.

I have reviewed the above options and elect to receive my benefit in the form indicated above. I understand that once benefit payments begin, my election may not be changed.

PARTICIPANT NAME: _____ SS# _____

PARTICIPANT SIGNATURE: _____ DATE: _____

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ELECTION FOR CALIFORNIA STATE TAX INCOME TAX WITHHOLDING

CHOOSE ONE:

_____ PLEASE WITHHOLD CALIFORNIA STATE TAX FROM MY DISTRIBUTION/
BENEFIT AT A RATE OF 10% OF THE AMOUNT FOR FEDERAL INCOME TAX.

_____ DO NOT WITHHOLD CALIFORNIA STATE INCOME TAX FROM MY DISTRIBUTION/
BENEFIT.

I represent that the foregoing information is correct and, if selecting a direct roll over, that the IRA or other qualified plan is eligible for and will accept a direct roll over.

Applicant's Name (Please Print) _____

Social Security Number: _____

Signature: _____ Date _____

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SPOUSAL CONSENT TO PARTICIPANTS'S ELECTION TO RECEIVE
INDIVIDUAL ACCOUNT IN FORM OTHER THAN QUALIFIED JOINT & SURVIVOR ANNUITY

I declare under penalty of perjury that I am the spouse of _____
(Participant's Name)

I hereby consent to my spouse's election to receive or pension benefit from the above plan in a form other than as qualified Joint & Survivor Annuity. I understand that this means that if my spouse's predeceases me, I will not receive the survivor annuity I would otherwise receive as required by law.

This consent will be valid only if recorded in the Plan's Administration office by the earlier of the date of death of the participant or the date benefit payments commence.

Dated _____
(Signature of Spouse)

Participant Name: _____ Spouse's Name: _____

SS# _____ SS# _____

.....

State of _____) On this the _____ day of _____, before me
County of _____) _____, the undersigned Notary Public,
personally appeared _____,
_____ Personally known to me
_____ Proved to me on the basis of satisfactory evidence to be the
person whose name _____.
Subscribed to the within instrument, and acknowledged that
_____ executed it.

WITNESS my hand and official seal.

Signature of Notary

**THIS FORM WILL NOT BE ACCEPTED UNLESS IT HAS BEEN COMPLETED IN
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STATEMENT FOR NON-MARRIED PARTICIPANTS

I, _____ do not wish to receive my benefit from the above plan in the form of a Qualified Joint and Survivor Annuity for the reason indicated below. I understand that rejecting this form benefit means no benefits will be paid to a spouse by the Retirement Plan after my death.

Choose one:

- I have never been and am not now legally married.
- I am legally divorced. (Submit complete copy of divorce decree & division of Community Property Assets)
- I am a widow/widower. (Submit copy of Death Certificate)
- I hereby swear that I am unable to locate my spouse (provide details – length of time, attempts to contact, etc)

_____ Date

_____ Participant Signature

_____ SS#

_____ Participant Name (Print)

.....

State of _____) On this the _____ day of _____, before me
County of _____) _____, the undersigned Notary Public,
personally appeared _____,
_____ Personally known to me
_____ Proved to me on the basis of satisfactory evidence to be the
person whose name _____.
Subscribed to the within instrument, and acknowledged that
_____ executed it.

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CERTIFICATION OF TERMINATED STATUS

I hereby swear that I have ceased work in the Hotel, Restaurant and Tavern industry and do not intend to return to work in the trade. My last date of employment in the industry was: _____.

_____ Date

_____ Participant Signature

_____ Social Security Number

_____ Participant Name (Print)

State of _____) On this the _____ day of _____, before me

County of _____) _____, the undersigned Notary Public,
personally appeared _____.
_____ Personally known to me
_____ Proved to me on the basis of satisfactory evidence to be the
person whose name _____.
Subscribed to the within instrument, and acknowledged that
_____ executed it.

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INSTRUCTIONS FOR SUBMITTING PROOF OF AGE

The acceptable proofs of age are listed below in two groups. Submit a photocopy of the proof of age listed in Group I, if you have it or can possibly obtain it.

If you cannot submit a proof in Group I classification, submit photocopies of two items listed in Group II.

Additional proofs of age may be requested if the documents you submit do not constitute convincing proof of age.

GROUP I – Submit one (1) of the following:

1. Birth Certificate
2. Baptismal Certificate or statement as to the date of birth shown by a church record, certified by custodian of such record.
3. Notification of registration of birth in public registry of vital statistics.
4. Certification of record of age by U.S. Census Bureau.
5. Hospital birth record, certified by the custodian of such record
6. Foreign church or government record.
7. Signed statement by the Physician or midwife who was in attendance at birth, as to the date of birth shown on their records.
8. Naturalization Records
9. Immigration Papers

GROUP II – Submit two (2) of the following:

1. Military Record
2. Passport
3. School records, certified by custodian of such records
4. Vaccination records, certified by custodian of such records
5. Insurance policy showing date of birth.
6. Marriage records showing date of birth
7. Letter from Social Security stating your date of birth as shown in their records.
8. Other evidence such as signed and notarized statements from persons having knowledge of your date of birth