SHEET METAL WORKERS' NATIONAL PENSION FUND

REACTIVATE FOR PENSION

Participant Name: _____

Local Union:_____

Last 4 digits of Social Security Number:_____

Address: _____

_____

_____

Telephone Number _____

Marital Status: _____ if applicable, your spouse's date of birth _____

***

Effective Date of Pension _____

Last Date of Work: _____

Certification, Signature and Date – By my signature, I certify that:

- I understand that my eligibility for benefits and the amount of my benefits are based on the accuracy of this application and other material and information I have provided to the Fund.
- All statements found in this application and in any other material I have submitted to the Fund are complete and accurate.
- The Trustees have the right to recover any payment made to me in error, or payments made because of any false or incorrect statements – whether deliberate, or by accident, mistake or misunderstanding.
- I must notify the Pension Fund office of any change in my personal, marital or employment status.
- I agree to be bound by all Plan Rules and Regulations as a condition of receipt of benefits.

_____ _____

Signature of Participant Date

NOTE: If you are applying for a disability benefit please refer to page 2 of this application for more information about eligibility.

8403 Arlington Blvd. Suite 300
Fairfax, VA 22031
info@smwnbf.org / fax 703.739.7836

INFORMATION ABOUT THE FULL DISABILITY BENEFIT

Please be advised that in order to qualify for a Disability Benefit a Participant must meet the following conditions:

1) The U.S. Social Security Administration has found him or her to be disabled as verified by proof of approval for Social Security Disability Insurance;
2) He must have earned a minimum of 10 years of Pension Credit, which must include a minimum of 5 years of Future Service Credit;
3) He worked in Covered Employment for at least 435-hours in the 24-month period that immediately preceded the date that he was found to be disabled by the U.S. Social Security Administration;
4) He has not at any time performed any work in the Sheet Metal Industry that was not covered by a collective bargaining agreement between the Union and the employer. (It should be noted that the Plan provides a limited opportunity to restore eligibility); and
5) **The Participant has not attained age 55.**

If eligible, the monthly amount of a Full Disability Benefit will be equal to the monthly amount of the early retirement pension that the Participant would have been eligible to receive if he or she **were age 55** on the effective date.

In order to be considered for a Full Disability Benefit you **must** complete this application and include a copy of proof of approval for Social Security Disability Insurance benefits from the U.S. Social Security Administration.

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DESIGNATION OF BENEFICIARY

As a Retiree, I hereby designate the following named beneficiary (ies) to receive the amount of **pension benefits**, if any, payable at my death, under the Rules and Regulations of the Sheet Metal Workers' National Pension Fund. I reserve the right to revoke and change this designation at any time by giving written notice to the Fund Office in the form designated by the Trustees.

Name of Primary Beneficiary: _____

Relationship: _____ Social Security Number: _____

Address of Primary Beneficiary: _____
(Number) (Street)

_____
(City) (State) (Zip Code)

Name of Successor Beneficiary: _____

Relationship: _____ Social Security Number: _____

Address of Successor Beneficiary: _____
(Number) (Street)

_____
(City) (State) (Zip Code)

If you wish to name additional beneficiaries, use an additional piece of paper listing the above information. Be sure to indicate if the designation is Primary or Successor beneficiary.

NOTE: This form is NOT intended to designate a Beneficiary (ies) for any Pre-Retirement Death Benefits that may be due if your death were to occur prior to your retirement. In that event, the Plan provides that **if** a benefit is payable it would be paid in equal share as follows:

- to your spouse, if you are not married
- to your children, if you have no children
- to your parents, if you do not have parents,
- to your siblings.

If none of the persons listed above survive you then no benefits are payable under the Plan.

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Authorization to Obtain Earnings Data from the Social Security Administration

Mail completed form to:	Social Security Administration PO Box 33011 Baltimore, MD 21290-3011
Requesting organization:	SSA Job No 8279 Index 01 Sheet Metal Workers National Pension Fund 8403 Arlington Boulevard, Suite 300 Fairfax, VA 22031

Number Holder's Information

First Name: Middle Initial:

Last Name:

SSN: -- --

Date of Birth: -- -- (Month Day Year)

Date of Death: -- -- (Month Day Year)

Other First, Middle Initial, and Last Name Used to Report Earnings:

Year(s) Requested: (Y Y Y Y) through (Y Y Y Y)

(Y Y Y Y) through (Y Y Y Y)

I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

Signature of Number Holder *(or authorized representative)*	Date -- -- (M M D D Y Y Y Y)
Printed Name *(if other than number holder)*	Relationship *(if other than number holder)* ☐ Spouse ☐ Legal Representative ☐ Other *(specify)*
Address / State	
City / ZIP Code	Phone Number

Requesting Organization's Information

SSA must receive this form within 120 days from the date signed by the Number Holder (or Authorized Representative)

Signature of Organization Official	Date
Phone Number	Fax Number

FOR SSA USE ONLY ☐1 ☐2 ☐3 ☐4

IMPORTANT INFORMATION

Privacy Act Statement
Collection and Use of Personal Information

Section 205(c)(2)(A) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to obtain earnings data. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed. We rarely use the information you supply us for any purpose other than to produce an itemized statement of earnings. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0059, entitled, Earnings Recording and Self-Employment Income System. Additional information about this and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA*, *6401 Security Blvd, Baltimore, MD 21235-6401.*