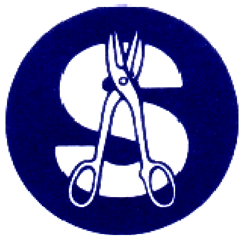

SHEET METAL WORKERS' NATIONAL PENSION FUND

REACTIVATE FOR PENSION

Participant Name: ____

Local Union:__________________

Last 4 digits of Social Security Number:______________________________

Address: ____

____

____

Telephone Number _____________________________ Email Address ___________________________

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.

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.

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

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.

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