

UFCW — EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA

DRAWER 9000 • WALNUT CREEK, CALIFORNIA 94598-0900 • (925) 746-7530 • (800) 794-5678

INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR RETIREMENT BENEFITS

- Complete both sides of the application in its entirety and sign the Authorization to obtain earnings data from the Social Security Administration.
- File the application and Authorization immediately with the Fund Office even though you may need further time to obtain some of the required documents. Forward the necessary documents to the Fund Office as soon as possible. The date the application is received may affect your eligibility for retroactive benefits.
- Keep a photocopy of your application and documents for your records.

Your application cannot be completed without the following documents:

- Proof of Date of Birth of Applicant (required of all applicants). Please list all names in the box "ALL OTHER NAMES" including maiden name and all previous married names, if applicable.
 - Certified Copy of Marriage License and Proof of Date of Birth of Spouse, if married. Please list all names used by your spouse in the box "SPOUSE'S PRIOR NAMES" including maiden name or previous married names, if applicable.
 - If filing for Social Security Adjustment Option, obtain a letter from your local Social Security Administration office stating the estimated retirement benefit you will receive at age 62, or if you desire, you may elect to use the standard average estimate calculated by the Fund Office.
 - If filing for Disability Retirement benefits, provide a copy of the Social Security Award Certificate issued to you stating your date of entitlement to Social Security Disability benefits.
 - If filing for Surviving Spouse benefits, as the legal surviving spouse of a vested member or retiree, attach a certified copy of the Death Certificate of the deceased member. Please complete this form as the Applicant for benefits and provide all available information regarding the Industry Employment of the deceased member. If the member was not retired, please also provide a Certified Copy of Marriage License and proof of the member's Date of Birth.
- Signed Authorization to Obtain Earnings Data from the Social Security Administration.
- If you were previously divorced and as a result there is a court order concerning your pension benefits, please provide a complete copy of the order.
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YOUR INITIAL RETIREMENT AWARD CHECKS, ONCE ISSUED, WILL BE FORWARDED TO YOUR UNION LOCAL OFFICE. THEREAFTER, THEY WILL BE MAILED TO YOUR DESIGNATED MAILING ADDRESS.

WE WILL PROVIDE INFORMATION ABOUT OUR DIRECT DEPOSIT SERVICE AND AN AUTHORIZATION AGREEMENT WITH YOUR INITIAL AWARD.

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RETIREMENT APPLICATION

UFCW-NORTHERN CALIFORNIA
EMPLOYERS JOINT PENSION PLAN

RETAIL CLERKS
SPECIALTY STORES
PENSION FUND

NO. CALIF. PHARMACISTS,
CLERKS & DRUG
EMPLOYERS PENSION FUND

APPLICANT'S NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER
STREET ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP	ALL OTHER NAMES (including maiden name)
AREA CODE & TELEPHONE NUMBER ()			
DATE OF RETIREMENT ____ / <u>01</u> / ____ MONTH DAY YEAR	LAST DAY ACTUALLY WORKED	LAST EMPLOYER	
SPOUSE'S NAME		HAS THE MEMBER EVER WORKED IN THE INDUSTRY OUTSIDE NORTHERN CALIFORNIA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SPOUSE'S DATE OF BIRTH	DATE OF MARRIAGE	If yes, provide location: _____ CITY STATE	
SPOUSE'S SOC. SEC. NO.	SPOUSE'S PRIOR NAMES (including maiden name)	DATES From _____ To _____	
WERE YOU EVER DIVORCED? NO ___ YES ___ *IF YES, PROVIDE DATE DIVORCE FINAL _____			
IF YOU WERE A UFCW UNION MEMBER, PLEASE LIST YOUR LOCAL _____			

I HEREBY APPLY FOR THE BENEFITS AS CHECKED BELOW. FOR A DESCRIPTION OF THE ELIGIBILITY RULES FOR EACH TYPE OF BENEFIT, PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION BOOKLET.

- Normal** – Normal Retirement Age with Vested rights.
- Early** – Early Retirement Age with Vested rights.
- Rule of 85** – Under Normal Retirement Age with Vested Rights and sum of age and Benefit Credits total 85 or more. (Available under the UFCW-Northern California Employers Joint Pension Plan only).
- Social Security Adjustment Option** – Age 55 to 62 with Vested rights. Amount of monthly benefit will be adjusted so as to provide a level monthly income for life taking into account anticipated Social Security benefits at age 62. Selecting this option makes you ineligible to receive a higher Disability Retirement Benefit, even if you subsequently receive a Social Security Disability Award from the federal government.
- Disability** – Under Normal Retirement Age with Vested rights and receiving Social Security Disability benefits first payable prior to a break in service.
- Survivor Benefits on behalf of deceased member** – provides survivor benefits to eligible surviving spouse or dependent child of a deceased member who had attained Vested rights and had met other requirements under the applicable Plan.

THIS DOCUMENT MUST BE SIGNED BY YOU **AND** A NOTARY PUBLIC **OR** AN AUTHORIZED UFCW UNION OFFICIAL **OR** AN AUTHORIZED FUND OFFICE REPRESENTATIVE.

I hereby certify that the information provided on this form is true and correct.

Applicant _____ Date _____

NOTARY: Subscribed and sworn by me on this Date _____

– OR – _____
(Signature)

UNION/FUND OFFICE:
REPRESENTATIVE _____
(Signature)

AFFIX OFFICIAL SEAL OR UNION STAMP

EMPLOYMENT HISTORY IN INDUSTRY IN NORTHERN CALIFORNIA

NAME OF STORE/COMPANY	CITY	CLASSIFICATION (CLERK, MEATCUTTER, PHARMACIST, MANAGER, ETC.)	DATES OF EMPLOYMENT				HOURS SCHED. WEEKLY
			FROM		TO		
			MONTH	YEAR	MONTH	YEAR	
PRESENT OR LAST EMPLOYER							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Complete the section below for ALL periods of your work history during which you were not in a union position in the industry:

REASON	FROM		TO	
	MONTH	YEAR	MONTH	YEAR
Military Service (Attach form DD-214)				
Illness or Injury (Supply doctor's name and address below) If disability began 3-1-92 or later, and you were absent from food or meat industry employment, submit copies of State Disability or Workers Compensation benefits.				
Exempt Employment in CA _____ <small>EMPLOYER/POSITION/LOCATION</small>				
UFCW Employment outside No. CA _____ <small>EMPLOYER/LOCATION</small>				
Worked in another industry or trade _____ <small>EMPLOYER/TYPE OF WORK</small>				
Self-Employment _____ <small>TYPE OF STORE/INDUSTRY/LOCATION</small>				
Other Reasons (State briefly and give dates)				

If you are not retiring directly from covered employment, indicate your work status from your last date of covered employment to the present. Please list the name of your employers, addresses, positions held and dates of employment.

AUTHORIZATION TO OBTAIN EARNINGS DATA FROM THE SOCIAL SECURITY ADMINISTRATION

Social Security Administration
Attention: DERO
300 N. Greene Street
Baltimore, Maryland 21201

Requesting Organization: Job No. **8316UV**
Name and Address:
UFCW – EMPLOYERS BENEFIT PLANS
ATTENTION: PENSION DEPARTMENT
DRAWER 9000
WALNUT CREEK, CA 94598-0900

Name _____ Social Security Number _____

Other Last Name(s), Such as
Maiden Name, Used to Report
Your/or the Deceased's Earnings _____

Date of Birth _____ Date of Death _____
(if applicable)

Please furnish the requesting organization shown above, 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 by that organization, and the identification numbers, names, and addresses of the reporting employers.

TO BE COMPLETED BY OFFICIAL OF REQUESTING ORGANIZATION ONLY

Periods Requested _____ through _____

Signature of Organization Official _____

Telephone Number _____ FAX Number _____

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. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Address/Telephone Number of _____
Social Security Number Holder _____
(or Authorized Representative)

Relationship (if other than SSN holder) _____

Date Signed _____ Signature of Social Security Number Holder
(or Authorized Representative)

Your Name (Please Print)

PRIVACY ACT STATEMENT

Section 205 (c) (2) (A) of the Social Security Act allows us to ask for the information you give us on this form. The information is needed so that the Social Security Administration can quickly identify your record or the record of the deceased individual who is the subject of a request you are making and prepare the earnings statement you want. You do not have to give us this information. However, without the information we may not be able to process your request. The information you provide will be used primarily for issuing the earnings statement you request. The information you provide may be given out if a Federal law requires that we give out the information; if a Congressman or the President's office needs this information to answer questions you ask them; or the Department of Justice needs the information for investigating or prosecuting violations of the Social Security Act.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this contact any Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 2 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.