

# UNITED INDUSTRIAL WORKERS PENSION PLAN APPLICATION

5201 Capital Gateway Drive  
Camp Springs, Maryland 20746-4275  
(301) 899-0675

Participant's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: ( ) Married ( ) Divorced ( ) Single ( ) Widow(er)

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone #: \_\_\_\_\_

*Spouse Information, If Applicable:*

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (If different from member): \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

First and Last Dates of Employment: First \_\_\_\_\_ Last \_\_\_\_\_

Other Union or Plan Affiliation: \_\_\_\_\_

**CHECK PENSION TYPE DESIRED**

**ELIGIBILITY REQUIREMENTS**

<input type="checkbox"/> <b>NORMAL</b>	<ul style="list-style-type: none"> <li>• Age 65</li> <li>• At least 25 years of benefit service with at least 1,800 hours in each year</li> </ul>
<input type="checkbox"/> <b>DEFERRED VESTED</b>	<ul style="list-style-type: none"> <li>• Age 65</li> <li>• At least one day of service after January 1, 1999 and have credit for 5 years of service with at least 1,000 hours of service in each year OR at least one day of service after January 1, 1976 and 10 years of service with at least 1,000 hours of service in each year</li> </ul>
<input type="checkbox"/> <b>EARLY</b>	<ul style="list-style-type: none"> <li>• Age 62</li> <li>• At least 15 years of benefit service with at least 1,800 hours in each year</li> </ul>
<input type="checkbox"/> <b>DISABILITY</b> <i>Date Disability Began</i> _____	<ul style="list-style-type: none"> <li>• At Any Age</li> <li>• At least 15 years of benefit service with at least 1,800 hours in each year</li> <li>• Must submit a Social Security Disability Award Letter OR receive a determination by the Board of Trustees</li> </ul>
<b>SURVIVOR'S PENSION -- Please contact Plan Office to request a Surviving Spouse Pension Application.</b>	<ul style="list-style-type: none"> <li>• Deceased participant must be either eligible (at date of death or in the future) for or was receiving a J&amp;S Annuity under one of the pension types indicated above.</li> </ul>

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Verified By: \_\_\_\_\_ Print Name: \_\_\_\_\_  
(Signature of Union Representative)

Date: \_\_\_\_\_ Office: \_\_\_\_\_

**\*\*IF YOUR SIGNATURE IS NOT VERIFIED BY UNION REPRESENTATIVE, IT MUST BE NOTARIZED BY A NOTARY PUBLIC\*\***

**The following documents must be submitted with the completed application:**

- Passport size photograph.
- A copy of participant's Birth Certificate (with seal or stamp).
- A copy of participant's Social Security Card or proof of your taxpayer ID Number.
- Any documents supporting military service.
- Signed Retirement Declaration.**  
(On Back of Application)

- If Married:**  
A copy of spouse's Birth Certificate (with seal or stamp).  
A copy of spouse's Social Security Card or proof of taxpayer ID Number.  
A copy of Marriage Certificate (with seal or stamp).
- If Divorced:**  
A copy of Divorce Decree(s) and any QDRO(s).
- If Spouse is Deceased:**  
A copy of Spouse's Death Certificate (with seal or stamp).

**DO NOT FORGET TO COMPLETE THE BACK OF THIS APPLICATION.**

# **UNITED INDUSTRIAL WORKERS PENSION PLAN**

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Camp Springs, Maryland 20746-4275  
(301) 899-0675

Margaret R. Bowen  
Administrator

## **RETIREMENT DECLARATION**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

I am submitting my application for retirement benefits from the United Industrial Workers (UIW) Pension Plan and I declare that I will be bound by the Rules and Regulations of the UIW Plan, including but not limited to the following:

- a) I hereby certify that as of the effective date of my pension benefit, I will have withdrawn from employment in a position covered by any collective bargaining agreement between the United Industrial, Service, Transportation, Professional and Government Workers of North America and any signatory company ("signatory employment").
- b) I understand that if, after beginning to receive pension benefits, I engage in signatory employment for a period of more than 40 hours in a month, my monthly benefits will be suspended. I understand that I will be required to return pension benefits previously paid to me during this period. Failing to do so may jeopardize my right to future benefits. Furthermore, I understand that when I terminate this signatory employment and my pension is resumed, any additional accruals will be added to the original amount of my benefit.
- c) The Plan Trustees have the authority to enforce the withdrawal provisions contained in paragraphs (a) & (b) above, and as a condition of receiving continued benefits, I will cooperate with any Plan investigation and provide copies of relevant earnings documentation or tax records if requested to do so.
- d) I understand that in the event that I wish to return to signatory employment, I must notify the Plan and obtain permission from the Trustees.
- e) I understand that if I am receiving a Disability Pension Benefit, I must be totally and permanently disabled. In the event that my condition improves and I no longer meet the criteria of being totally and permanently disabled, I understand that my disability benefits from the Plan will terminate. I may be required to submit to a physical examination if requested by the Plan.

**THIS IS A LEGAL DOCUMENT.  
THE PLAN WILL RELY ON YOUR RETIREMENT DECLARATION.  
SIGN UNDER PENALTY OF LAW.**

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**Participant's Signature**

**Date**

**\* The withdrawal provision does not apply to those pensioners receiving mandatory pension benefits. These are pensioners who commence their benefits on April 1<sup>st</sup> of the calendar year that follows the date they reach age 70 ½.**