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.

3180 Fairview Park Drive, Suite 400
Falls Church, VA 22042
info@smwnbf.org / Phone: 1.800.231.4622/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 3180 Fairview Park Drive Suite 400 Falls Church, VA 22042

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, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from furnishing detailed earnings information.

We will use the information to produce detailed earnings information about the wage earner. We may also share your information for the following purposes, called routine uses:

- To employers or former employers, including State Social Security administrators, for correcting and reconstructing State employee earnings records and for Social Security purposes; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0059, entitled Earnings Recording and Self-Employment published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

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 (OMB) 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 regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*