

APPLICATION FOR PRE-RETIREMENT DEATH BENEFITS

RETURN TO:

Plumbers Local Union No. 519 Pension Trust Fund

C/O National Employee Benefits Administrators

2010 N.W. 150th Avenue, Suite 100 • Pembroke Pines, FL 33028

Please print or type

| | | | | | |
|---|------------------------|---------------------------|--|--|--------------------|
| NAME OF APPLICANT (Last, First, Middle) | | | NAME OF DECEASED PARTICIPANT (Last, First, Middle) | | |
| ADDRESS (Where correspondence should be sent) | | | SOCIAL SECURITY NUMBER | LOCAL UNION NUMBER | DATE OF INITIATION |
| CITY, STATE, ZIP | | | DATE OF BIRTH (Month, Day, Year) | DATE OF DEATH ((Month, Day, Year) <small>ATTACH COPY OF DEATH CERTIFICATE</small>) | |
| DATE OF BIRTH | SOCIAL SECURITY NUMBER | TELEPHONE NUMBER () | MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | |

RELATIONSHIP OF APPLICANT TO DECEASED PARTICIPANT

IF SPOUSE COMPLETE THE FOLLOWING

DATE OF BIRTH (Month, day, Year) ATTACH PROOF

DATE OF MARRIAGE (Month, Day, Year)

| | | | | | |
|--|--------------|------------|--|--------------|------------|
| WAS THE PARTICIPANT EVER A SOLE PROPRIETOR OR A PARTNER IN A COMPANY IN THIS INDUSTRY <input type="checkbox"/> YES <input type="checkbox"/> NO | | | LIST BELOW ANY INTERRUPTIONS OF THE PARTICIPANTS EMPLOYMENT IN THE INDUSTRY DUE TO DISABILITY, MILITARY SERVICE, MATERNITY OR PATERNITY LEAVE, OR WORK FOR A SIGNATORY EMPLOYER IN NON-COVERED EMPLOYMENT. | | |
| IF YES, PLEASE COMPLETE THE FOLLOWING | | | | | |
| NAME AND TYPE OF BUSINESS | FROM (MO/YR) | TO (MO/YR) | NAME AND TYPE OF BUSINESS | FROM (MO/YR) | TO (MO/YR) |
| | | | | | |
| | | | | | |

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

TO SUPPORT THIS APPLICATION, I AM ATTACHING A CERTIFIED COPY OF THE DEATH CERTIFICATE.

NOTE: IF THE PARTICIPANT WAS VESTED AND MARRIED AT THE TIME OF DEATH. THEN THE SPOUSE IS ENTITLED TO A MONTHLY SURVIVOR BENEFIT. THIS MONTHLY BENEFIT, HOWEVER, MAY NOT BE PAYABLE UNTIL THE PARTICIPANT WOULD HAVE REACHED THE EARLIEST RETIREMENT AGE UNDER THE PENSION PLAN

| | |
|----------------------------------|------|
| SPOUSE / BENEFICIARY'S SIGNATURE | DATE |
| WITNESS SIGNATURE | DATE |

APPLICANT

THE MONTHLY DISTRIBUTION YOU COULD RECEIVE FROM THE RETIREMENT PLAN IS SUBJECT TO FEDERAL INCOME TAX WITHHOLDING UNLESS YOU ELECT NOT TO HAVE WITHHOLDING APPLY.

YOU MUST ELECT ONE OF THE FOLLOWING AND RETURN THIS SIGNED FORM TO THE FUND'S ADMINISTRATIVE OFFICE.

- I DO NOT WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY DISTRIBUTION.
- I DO WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY DISTRIBUTION.

EVEN IF YOU ELECT NOT TO HAVE WITHHOLDING APPLY, YOU MAY BE LIABLE FOR PAYMENT OF FEDERAL INCOME TAX. YOU MAY ALSO HAVE TO PAY A PENALTY UNDER THE ESTIMATED TAX RULES IF YOUR WITHHOLDING AND ESTIMATED TAX PAYMENTS ARE NOT SUFFICIENT.

| | |
|--------------------------|------|
| PARTICIPANTS BENEFICIARY | DATE |
|--------------------------|------|

ATTACH COPY OF APPLICANTS BIRTH CERTIFICATE AND, IF MARRIED, A COPY OF THE MARRIAGE CERTIFICATE AND THE SPOUSE'S BIRTH CERTIFICATE.