

# APPLICATION FOR RETIREMENT OR DISABILITY BENEFITS

RETURN TO:

## Plumbers & Pipefitters of the Carolinas Defined Contribution Plan C/O National Employee Benefits Administrators

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

Please print or type

NAME (Last, First, Middle)			MARITAL STATUS Attach Marriage Certificate or Divorce Decree/Settlement Agreement <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
ADDRESS (Where correspondence should be sent)			NAME OF SPOUSE (Last, First, Middle)	
CITY, STATE, ZIP			SPOUSE SOCIAL SECURITY NUMBER	DATE OF MARRIAGE
DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER (   )	SPOUSE DATE OF BIRTH (Attach birth certificate or other proof)	

BENEFICIARY NAME (Last, First, Middle)		CONTINGENT BENEFICIARY NAME (Last, First, Middle)	
ADDRESS OF BENEFICIARY		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
RELATIONSHIP	SOCIAL SECURITY NUMBER	RELATIONSHIP	SOCIAL SECURITY NUMBER

TYPE OF RETIREMENT FOR WHICH YOU ARE APPLYING <input type="checkbox"/> Normal <input type="checkbox"/> Early <input type="checkbox"/> Late <input type="checkbox"/> Disability		IF DISABILITY ATTACH COPY OF SOCIAL SECURITY AWARD LETTER.	DATE FIRST EMPLOYED IN THIS JURISDICTION	
LAST DAY WORKED OR EXPECTED TO WORK (Month, Day, Year)		LAST EMPLOYER FOR WHICH YOU WORKED	I PLAN TO RETIRE ON (Month, Day, Year)	
HAVE YOU APPLIED FOR RETIREMENT BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, CHECK TYPE OF RETIREMENT YOU APPLIED FOR <input type="checkbox"/> Normal <input type="checkbox"/> Early <input type="checkbox"/> Disability		
ARE YOU NOW OR WERE YOU EVER A SOLE PROPRIETOR OR A PARTNER OF A COMPANY IN THIS INDUSTRY? <input type="checkbox"/> YES <input type="checkbox"/> NO		LIST BELOW ANY INTERRUPTION IN YOUR EMPLOYMENT IN THE INDUSTRY DUE TO DISABILITY, MILITARY, MATERNITY OR PATERNITY LEAVE, OR WORK FOR A SIGNATORY EMPLOYER IN NON-COVERED EMPLOYMENT.		
IF YES, PLEASE COMPLETE THE FOLLOWING				
NAME & TYPE OF BUSINESS	FROM (MO/YR)	NAME & 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. I ALSO CERTIFY THAT I WILL ADHERE TO THE RETIREMENT REQUIREMENT OF THE PLAN. I UNDERSTAND A FALSE STATEMENT MAY DISQUALIFY ME FOR BENEFITS. THIS APPLICATION REVOKES ANY PRIOR APPLICATIONS AND DESIGNATIONS OF BENEFICIARIES.

PARTICIPANT'S SIGNATURE		DATE
WITNESS SIGNATURE		DATE
LOCAL UNION NUMBER	UNION MEMBERSHIP NUMBER	

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

IF A DISABILITY APPLICATION, ATTACH A COPY OF SOCIAL SECURITY AWARD OR OTHER PROOF OF DISABILITY.

