IBEW LOCAL NO. 640 & ARIZONA CHAPTER NECA
PENSION PLAN – BENEFIT APPLICATION
CHECKLIST AND INFORMATION

1. Please print.

2. Be sure to answer all questions carefully and to the best of your ability. Failure to complete the entire application will delay your Pension Benefit Payments.

3. IF YOU ARE MARRIED, YOU MUST SUBMIT A COPY OF YOUR MARRIAGE CERTIFICATE AND YOUR SPOUSE'S BIRTH CERTIFICATE.

4. IF YOU ARE DIVORCED, YOU MUST SUBMIT A COPY OF YOUR ENTIRE DIVORCE DECREE AND ANY DOMESTIC RELATIONS ORDER (DRAFT OR FINAL).

5. If you are married, your Spouse must also sign and date the Husband & Wife Election form. Your spouse's signature must be notarized.

6. A copy of your birth certificate must be submitted along with the completed application package.

7. Mail the completed application to: IBEW Local No. 640 & AZ Chapter NECA
Pension Trust Fund
2001 W. Camelback Rd. Ste. B350
Phoenix, AZ 85015

You may change or revoke your elected benefit form at any time during the 90-day period ending on the date of your benefits are paid to you.

If you have any questions pertaining to the completion of this application package please contact the Trust Fund Office for assistance at the address above or call 602-650-8119

APPLICATION FOR PENSION BENEFITS

Name: ____
Last First Middle Initial

Address: ____
Mailing address City state Zip

Email: ______________________________________

Social Security No: ____________________ Phone No: ____________________

Birth Date: ______________________ (Attach proof of age, i.e., birth certificate)

Emergency contact: ____________________________ Phone No: _______________

Date you last worked, or intend to work: ____________________________

Employer: ____

Retirement Effective Date: _________________________________

Have you been in Military Service? _______ If so, provide dates: ______________through______________

Marital Status (Check all that apply):

______Single (Never Married) _____ Widowed (attach copy of Death certificate)

______Divorced / Date __________ (attach a copy of your divorce decree including property settlement)

________ I am covered by a QDRO that would affect my benefits. (Enclose a copy)

______Married / Date of Marriage ____________________ (attach copy of marriage certificate)

Spouse's Name ________________________ Date of Birth _________________

Social Security ___________________

I hereby apply for a pension from the I.B.E.W Local 640 Pension Trust Fund. I certify under penalty of perjury that all the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for pension benefits and the Trustees shall have the right to recover any payment made to me because of a false statement.

____ ____________
Member's Signature Date

IBEW LOCAL UNION # 640
PENSION TRUST FUND

BENEFIT ELECTION

If eligible, I wish to retire on a (please select one)

☐ REGULAR PENSION (You must be at least 62 years of age)

☐ EARLY PENSION (You must be between the ages of 55 through 61)

Please see the attached notice titled "Consequences of Failure to Defer Benefits"

☐ SERVICE PENSION (You must be between the ages of 55 through 61 and have at least 35 years of pension credit)

☐ DISABILITY PENSION (please attach a copy of your Social Security Disability Award Letter). If you have not been awarded Social Security Benefits, you must provide the Trust Office with copies of your medical records (please provide as much information as possible).

PRO-RATA PENSION DATA

_____Pro-Rata Pension. To be eligible for this form of pension benefit payment, the Participant must have accumulated pension credits with the following Participating Trust Fund. *(Please indicate the dates employed in the space provided below.)*

IBEW Local Union Nos. 570 and 518 and Saguaro Chapter NECA Pension Plan.

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IBEW LOCAL UNION # 640
PENSION TRUST FUND

HUSBAND AND WIFE PENSION ELECTION FORM

Under this Pension Plan your benefit will be paid as a Husband and Wife Pension if you are married when you retire, unless you and your Spouse reject that form of payment. *This rejection must be in writing and contain the notarized signatures for you and your Spouse.* The Husband and Wife Pension provides for a reduction in the monthly pension for the life of the Pensioner. When the Pensioner dies, the Spouse will receive a lifetime pension equal to 50% or 75% (whichever form you choose) of the amount that was being paid to the Pensioner when he/she was alive. If the Husband and Wife option is elected, and the Spouse predeceases the Pensioner, the monthly amount paid to the Pensioner will be increased so as to equal the monthly pension that would have been payable had your benefits been paid in the form of a single life option.

If you wish to receive your benefits in the form of a Husband and Wife Pension, you will receive a benefit that has been actuarially reduced to reflect protection over two lifetimes. After your death, your surviving Spouse will receive 50% or 75% (whichever form you choose) of your benefit per month for their lifetime. Under the Husband and Wife Pension, if your Spouse were to predecease you, your monthly benefit amount would rise up to the amount you would have received had you rejected this form of payment.

If you do not wish to receive your benefits in the form of a Husband and Wife Pension, you will have no actuarial reduction applied to your monthly benefit.

Please complete the form below and return it to the Fund Office immediately indicating your choice as to how you wish to receive your pension benefits. You and your Spouse must sign the back of this form in front of a Notary Public. If you are not married, or cannot find your Spouse, the back of this form still must be signed in front of a Notary Public.

Please make your election below. Please check one**.**

☐ **50% Husband and Wife Joint & Survivor Annuity with Pop-Up**

This Annuity, or the 75% Husband and Wife Annuity, are the automatic forms for all Participants who have been married on their pension effective date. You may select either the 50% option or the 75% option, but cannot choose the 36 month Single Life Annuity without notarized spousal consent on the form below. Note: the only "spouse" who can qualify for this benefit is the person married to the Participant upon retirement, except for a *prior* spouse pursuant to a Qualified Domestic Relations Order. A future spouse or widow (someone you marry after you retire) can *never* be your surviving spouse under a JSA.

Under this benefit you will receive $________ your lifetime and upon your death your spouse will receive a monthly benefit of $________. If your spouse predeceases you, your monthly benefit will "pop-up" to the full Single Life Annuity amount (Normal or Early) beginning with the next monthly payment after your spouse's death.

☐ **75% Husband and Wife Joint & Survivor Annuity with Pop-Up**

Available 1/1/2009 and after.
Under this benefit you will receive $________ for your lifetime and upon your death your spouse will receive a monthly benefit of $_________.
All other features are as stated above for the 50% Husband and Wife JSA.

☐ **36 – Month Guaranteed Single Life Annuity**

This option provides an unreduced monthly benefit to you for your lifetime, with a minimum guarantee of 36 payments. If you die before receiving all 36 payments, your designated beneficiary (who may or may not be your spouse), will receive the remaining payments until 36 total payments are made

Under this benefit you (or your designated beneficiary) will receive $________ monthly for a total of at least 36 monthly payments.

_______________________________________ ____________________

Signature of Employee Date

_______________________________________ ____________________

Social Security No. Local Union #

SIGNATURE AUTHORIZATION AND NOTARIZED CERTIFICATION

EMPLOYEE'S STATEMENT

I hereby apply for my Pension benefit from the IBEW Local Union No. 640 & Arizona Chapter NECA Defined Benefit Pension Plan. I certify under penalty that all of the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for a benefit and that the Trustees will have the right to recover any payment made to me because of a false statement.

CHECK ONE:
- ☐ I hereby swear that the person co-signing this document below is my current legal Spouse.
- ☐ I hereby swear that I am unable to locate my Spouse.
- ☐ I hereby swear that I am not legally married at this time.

_______________________________________ ____________________

Participant's Signature Date

On this _______ day of ____________________, 20___ before me came _________________________________ to me known to be the person described in and who executed the foregoing statement and (s) he duly acknowledged to me that (s) he executed same.

Notary Public: _________________________________

My Commission Expires: _______________________________

SPOUSE'S STATEMENT

I, swear that I am the legal Spouse of the Employee described above. I hereby consent to all of the choices made by my Spouse in this application I understand that if my Spouse did not elect the 50% or 75% Husband and Wife Joint and Survivor Annuity I will not be paid a pension from the Plan after my Spouse's death unless benefits are payable under other sections of the Plan.

____ ___________________

Spouse's Signature: Date:

On this _______ day of ____________________, 20____ before me came _________________________________ to me known to be the person described in and who executed the foregoing statement and (s) he duly acknowledged to me that (s) he executed same.

Notary Public: _________________________________

My Commission Expires: _______________________________

Beneficiary Designation

I hereby designate the following beneficiary to receive any payments under the Plan which may be due in the event of my death, unless a different beneficiary is named hereafter, properly designated by me. If I name my spouse and my marriage is subsequently dissolved or annulled, the designation of that former spouse will be void.

Name: _______________________________________ Relationship: __________ Percentage _________

Birth Date: ______________________ Social Security Number: ____________________________

Address: ____

Name: _______________________________________ Relationship: __________ Percentage _________

Birth Date: ______________________ Social Security Number: ____________________________

Address: ____

Name: _______________________________________ Relationship: __________ Percentage _________

Birth Date: ______________________ Social Security Number: ____________________________

Address: ____

IBEW LOCAL UNION #640
PENSION TRUST FUND

AUTOMATIC DEPOSIT OF PENSION CHECKS
BY ELECTRONIC FUND TRANSFER

I hereby authorize the IBEW Local No. 640 and Arizona Chapter NECA Pension Trust Fund, hereinafter called The Fund, to initiate credit entries and to initiate, if necessary, debit entries, and adjustments for any credit entries in error to my Account as described below at the Financial Institution (Depository) names below.

NAME OF FINANCIAL INSTITUTION: ____

ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP: __________

PLEASE ATTACH A **VOIDED CHECK** FOR VERIFICATION PURPOSES

Routing No.: ______________________________

Account No.: ______________________________

Account Type:

☐ Checking ☐ Savings

This authority is to remain in full force and effective until the Fund has received written notification from me of its termination in such time and in such manner as to afford the Fund and the Bank a reasonable opportunity to act on it.

______________________________ ______________________________

Please Print Name Signature of Retiree

______________________________ ______________________________

Social Security Number Date

NOTE: New requests for Electronic deposits and changes to previous Electronic Transfers will take 2 months to become effective.

Remember to keep the Fund Office advised of your correct mailing address for correspondence purposes.

IBEW LOCAL UNION #640
PENSION TRUST FUND

Requirements for Continued Retiree Health & Welfare Benefits

A former Active Employee or former Non-Jobsite Employee (which former Non-Jobsite Employee has been covered for Fund benefits during the 36 consecutive months prior to retirement) who loses eligibility due to retirement may elect, **in lieu of the self-payment benefits provided under Article II, Subsection A of Section 6 of the Health & Welfare Plan Rules and Regulations** to continue eligibility for **Medical, Dental Benefits** for himself and his eligible Dependents. To do so, he must make self-payments, provided that such former Active Employee or former Non-Jobsite Employee had work activity under this Plan which, if applied under the IBEW Local Union No. 640 and Arizona Chapter NECA Pension Trust Fund, would have given rise to 10 years or more of Pension Credit, and provided he was eligible for coverage when he retired. In order to be eligible to make self-payments under this provision, **a person must have been an Active Employee covered by the Fund who failed to maintain that status because of retirement.**

Notwithstanding the foregoing limitation, if a former Active Employee or former Non-Jobsite Employee who has the equivalent of 25 years of Pension Credit and is formally retired under the IBEW Local Union No. 640 and Arizona Chapter NECA Pension Trust Fund, he and his eligible Dependents will be allowed coverage for Medical, Dental and Vision Benefits by making self-payments effective with the first month of retirement.

RETIREE SELF-PAY AUTHORIZATION FORM

____ _________________________________

Name of Retiree Social Security Number

I hereby authorize the IBEW Local Union No. 640 and Arizona Chapter NECA Pension Trust Fund to withhold the self-payment amount required by the IBEW Local Union No. 640 and Arizona Chapter NECA Health & Welfare Trust Fund from my monthly pension benefit and to remit it to the Fund to continue my retiree health and welfare benefits. ***Please note if Self-Pay Employees and/or their Eligible Dependents are eligible for Medicare or are age 65 or older, payment of benefits provided by the Fund is based on the assumption that the individual is eligible for both Parts A and B of Medicare. Regardless of whether or not you chose to enroll in both Parts A and B of Medicare.**

This authorization shall terminate:

1. If I cease to be eligible for a monthly pension benefit from the Pension Trust Fund; or
2. If I notify the Pension Trust Fund's Administrative Office in writing of my revocation of this authorization.

I understand that after January 1, 1985, my participation in the Health & Welfare Fund can only be allowed if I execute this authorization form, and that if I revoke it under paragraph 2 above, my continued participation in the Health & Welfare Fund will terminate.

☐ I hereby **Elect** participation in the Health & Welfare Fund.

☐ I hereby **Reject** participation in the Health & Welfare Fund.

___________________________________ __________________

Signature of Retiree Date

IBEW LOCAL UNION # 640
PENSION TRUST FUND

PENSION BENEFIT TAX WITHHOLDING ELECTION

Name: ______________________________________ Social Security #: ____________________________

I understand that unless I indicate otherwise, in the event that my monthly pension benefit from the IBEW Local No. 640 & Arizona Chapter NECA Pension Trust Fund is at least $2,033.00 per month, Federal Withholding taxes will be deducted based on a status of MARRIED and entitled to THREE EXEMPTIONS.

If my monthly pension benefit is less than $2,033.00 per month, no deduction will be made for the purpose of Federal Withholding taxes unless I request a deduction.

FOR THE PURPOSE OF FEDERAL WITHHOLDING TAXES, I AM REQUESTING THE FOLLOWING:

☐ DO NOT make any deduction for the purpose of Federal Withholding taxes.

☐ I would like a deduction to be made from my monthly pension benefit check for the purpose of Federal Withholding taxes based on the following status:

☐ Married ☐ Single Indicate the number of exemptions you are claiming: __________

☐ Please deduct $______________ each month from my pension benefit check for the purpose of Federal Withholding taxes.

FOR THE PURPOSE OF STATE WITHHOLDING TAXES, I AM REQUESTING THE FOLLOWING:

☐ DO NOT make any deduction for the purpose of State Withholding taxes.

☐ I hereby elect to have my State Withholding taxes equal to:

☐ 34.4% of Federal Withholding Tax
☐ 29.4% of Federal Withholding Tax
☐ 23.3% of Federal Withholding Tax
☐ 21.3% of Federal Withholding Tax
☐ 18.2% of Federal Withholding Tax
☐ 10.0% of Federal Withholding Tax
☐ My annual pay is less than $15,000. I understand that $5 per month is a minimum mandatory State Withholding and make no other election.

_______________________________________ ________________________

Signature of Retiree Date

IBEW LOCAL UNION # 640
PENSION TRUST FUND

Retirement Declaration

____ ____________________________

Name Social Security Number

In retiring on a Pension from the IBEW Local Union No. 640 and Arizona Chapter NECA Pension Trust Fund, I declare that I will be bound by all the Rules and Regulations of the Pension Plan, and:

1. I understand that to be considered retired, commence pension benefits, and continue to receive benefits under the Plan before age 65, I must completely withdraw from and refrain from any **work** or activity for wage or profit in the electrical industry wherever such employment or activity may be performed.

   I understand that to be considered retired and eligible to commence benefits after age 65, my pension will not commence in a month in which I work in Covered Employment. Subsequently my benefits will be suspended if I work more than 40 hours in any calendar month in any business activity of any employer, including supervisory employment and self-employment, in the same industry, in the same trade or craft in the area of the Fund or in the area of a Related Plan.

2. I understand that if I am employed in work of the type described above, my pension payments shall be suspended for any calendar month in which I am so employed and for six additional months after I cease employment. After that period, my pension shall again become payable.

3. I understand that if I am employed in work of the type described above, I must notify the Trustees in writing within 21 days following the commencement of such employment.

If I fail to give such written notice within such 21-day period, my pension may be suspended at the discretion of the Trustees for an additional period of six months over and above the suspension period specified above.

LAST DATE WORKED IN COVERED EMPLOYMENT: ________________________________

LAST EMPLOYER: ____

LAST DAY WORKED IN ANY EMPLOYMENT_____________ EMPLOYER ___________________

Did you work in the electrical industry (Non-union or Union) after age 65 in Arizona?________________

If so, last date worked:____________________ Employer:__________________________

______________________________ ________________________

Signature Date