MILLWRIGHTS' LOCAL 1102 SUPPLEMENTAL PENSION FUND
REQUEST FOR APPLICATION FOR
DISABILITY BENEFITS

RETURN COMPLETED FORM TO: **Board of Trustees**
Millwrights' Local 1102 Supplemental Pension Fund
6525 Centurion Drive
Lansing, MI 48917-9275

I hereby request an Application Form so that I might apply:

☐ **Disability Benefits**

To be effective _____ 1, _____.
(Month) (Year)

IMPORTANT INFORMATION: under the terms of the Plan and the Internal Revenue Service requirements, "retirement" means a participant has separated from service of an employer. Therefore, participants retiring must have separated from service for one (1) payroll reporting calendar month with no hours worked in covered service immediately after the above stated retirement date before a retirement benefit can be issued. Your check will not be issued until the employer hours and contributions records are received and reviewed by the Fund Office for the month you are retiring. After this verification, a check will be issued.

RETIREMENT BENEFITS: Your second and final distribution will be equal to your account balance as of the prior annual valuation date adjusted, up or down, for Fund investment returns as of the last day of the month preceding your Retirement Date or your "Application For Benefits" received date as stated above if it is received after the intended Retirement Date.

I hereby submit the following personal information (Please type or print):

_____
Name (First, Middle, Last)

_____
Social Security Number

_____
Street Address

_____
City State Zip

_____
Date of Birth Phone Number (include area code)

_____
Current Local Union # (If any) Initiation Date into that Local

_____
If you have had contributions made on your behalf to another Millwrights' Pension Fund, please list name of Fund and Location

_____
Local Union # Year(s)

PLEASE COMPLETE AND SIGN THE OTHER SIDE

The last date worked or expected to work before retirement: _____
(If date is not completed, we will assume that you will continue to work through the month immediately preceding the effective date you indicated above.)

_____
Name of Last Contributing Employer (include telephone number)

Please indicate your marital status, where applicable:

- ☐ Single
- ☐ Married, number of times _____
- ☐ Divorced, number of times _____, or Widowed _____

If currently married, please indicate the following:

_____
Spouse's First, Middle, Last Name

_____
Spouse's Social Security Number Spouse's Date of Birth

_____
Date of marriage

If you intend to select a designated beneficiary other than your spouse, please complete the following:

_____
Beneficiary's First, Middle, Last Name

_____
Beneficiary's Social Security Number Beneficiary's Date of Birth

Please indicate if you have applied for benefits from one of the Pension Funds shown below:

- ☐ Carpenters' Pension Trust Fund – Detroit and Vicinity, Effective Date: _____
- ☐ Michigan Carpenters' Pension Fund, Effective Date: _____

If you have not already done so, you must provide the Fund Office with the following items:

- Proof of Birth
- Spouse's Proof of Birth
- Spouse's Copy of Drivers' License
- Marriage Certificate
- Copy of Drivers' License
- All Divorce Decrees

CERTIFICATION

I hereby certify that all of the information furnished by me on this Request for Application Form is, to the best of my belief and knowledge, true and complete. I understand that this completed Request Form will be attached to and become part of my Application for benefits Form and that when I do submit such Application, I must also submit acceptable proof of my age and, if I am then married, proof of my spouse's age, as well as a photocopy of my Marriage License or Certificate. I also understand that if I am divorced, I must submit a copy of my Judgment(s) of Divorce or Divorce Decree(s) with all attachments, and, if I am widowed, I must submit a copy of my deceased spouse's Death Certificate. I further understand that any material misrepresentation of such as my marital status constitutes fraud and may result in a complete loss of my supplemental pension.

_____ _____
Signature of Participant Date Signed

FUND: MILLWRIGHTS LOCAL 1102 SUPPLEMENTAL PENSION FUND

APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS

I hereby apply for **Total and Permanent Disability Benefits** from the Millwrights Local 1102 Supplemental Pension Fund. I understand that eligibility for these benefits is conditioned upon my physical condition as determined by the Trustees.

I hereby authorize the Board of Trustees or the Administrative Manager of the Fund to obtain from my Physician whatever information deemed necessary to investigate or substantiate my claim for disability hereunder, and I hereby authorize my Physician (whose name and address appear below) to release such information to the Board of Trustees or the Administrative Manager upon written request when accompanied by a photocopy of this application form.

MY PHYSICIAN IS (Please type or print):

_____

(First Name) (Middle Initial) (Last Name) (Degree)

_____

(Street Address) (City) (State) (Zip Code)

I hereby submit with this Application, a Physician's Medical Report, completed by my Physician, attesting to my disabled condition, and submit my Birth Certificate and Marriage Certificate (if applicable).

I UNDERSTAND THAT, IF I HAVE FILED FOR AND RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD ATTACH A COPY OF IT TO THIS APPLICATION. IF I DO NOT HAVE A DISABILITY AWARD OR APPROVAL FOR DISABILITY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION, DOCTORS REPORTS AND STATEMENTS REGARDING MY DISABILITY SHOULD BE SUBMITTED TO SUBSTANTIATE MY DISABILITY (DO NOT SEND X-RAYS OR MRI IMAGES).

I FURTHER UNDERSTAND THAT, IF I HAVE NOT RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION OR HAVE BEEN DENIED SAID AWARD, MY APPLICATION WILL BE SUBMITTED TO THE BOARD OF TRUSTEES ALONG WITH MY MEDICAL EVIDENCE FOR APPROVAL.

PERSONAL INFORMATION (Please type or print):

Name of Applicant: _____

(First Name) (Middle Initial) (Last Name)

Social Security Number: _____Date of Birth: _____

Home Address: _____

(Street) (City) (State) (Zip Code)

Home Telephone Number: _____Present Local Union Number: _____

Have you ever received Workers' Compensation Benefits, which are related to this disability?

☐ Yes ☐ No

If yes, please submit proof from the time you started collecting Workers' Compensation Benefits through the ending time or through the present (if still collecting), and proof of the weekly rate of benefits. (*You can obtain this information from your insurance carrier who handles your Workers' Compensation.)*

Last day of work before this disability occurred: _____

Name of Last Employer: _____Employer's Phone No. _____

MAILING INSTRUCTIONS (Complete only if different than the "Home Address" shown on the other side.):

Mail Benefit Check to:_____
(First Name) (Middle Initial) (Last Name)

_____
(Street) (City) (State) (Zip Code)

I hereby certify that the above information is, to the best of my belief and knowledge, true and complete. Before final action is taken on this application, I understand it will be necessary for me to provide the Trustees of the Supplemental Pension Fund with a Physician's Medical Report, documentary proof of my Date of Birth, a copy of my Disability Award from the Social Security Administration, if any, and a copy of the Notice of Commencement of Compensation Payments from Workers' Disability Compensation, if applicable:

Date: _____ **Signature of Applicant:** _____

PHYSICIAN'S MEDICAL REPORT
(To be completed by Applicant's Physician)

TO: THE BOARD OF TRUSTEES OF THE MILLWRIGHTS LOCAL 1102 SUPPLEMENTAL PENSION FUND

RE: Name: _____Social Security Number:_____

Address: _____City:_____State:_____Zip Code:_____

Diagnosis: _____

Concurrent Conditions: _____

When did these symptoms first appear or accident/injury happen? Date: _____

Is the disability due to accident/injury or sickness arising out of the patient's employment? □ Yes □ No

When did the patient first consult you for this condition? Date: _____

How long have you know this patient? Since _____

When did you last examine this patient for this condition? Date: _____

Based on your examination of and conversation with the patient,

Was the disability contracted, suffered or incurred while he/she was engaged in or the result of his/her having engaged in a criminal enterprise? □ Yes □ No

Was the disability self-inflicted? □ Yes □ No

Is this patient totally unable to engage in his/her regular occupation or employment at the Millwright Trade as the result of this disability? □ Yes □ No

As of what date did this occur? Date: _____

Do you consider this disability to be permanent? □ Yes □ No

If no, what is the probable future duration? _____

_____

What employment can this patient engage in? _____

_____

What employment is this patient restricted from? _____

_____

_____

Physician's Signature: _____

Please type or print the following:

Physician's Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____
(Area Code)

Date_____

MILLWRIGHTS LOCAL 1102 SUPPLEMENTAL PENSION FUND
6525 Centurion Drive
Lansing, MI 48917-9275

(517) 321-7502 • FAX (517) 321-7508
TOLL FREE (888) 228-6700