# Northern California Plasterers Trust Funds

Health & Welfare Trust Fund, Pension Plan and Plasterers Local 66 Supplemental Pension Trus 4160 Dublin Boulevard, Suite 400, Dublin, CA 94568-7756 Toll Free: 1-(844) 663-8121 \* Fax: 1-(925) 833-7301

Email: plasterersinfo@hsba.com

#### **APPLICATION FOR DISTRIBUTION**

# INSTRUCTIONS

- Please read and complete each section carefully.
- ❖ Mark "N/A" (Not Applicable) if the requested information does not apply to you.
- Print or type your answers (except signatures).
- Sign and date the Application.
- Mail the completed Application and required attachments to the Plan Office.

Be sure that your answers are accurate. Incorrect or incomplete information will delay receipt of your benefits.

benefits.								
PERSONAL DATA								
1. Name								
	Last	First Middle						
2. Address								
Z. Address	No. and Street							
	110. and Stroot							
	City	State Zip Code						
3. Telephone No.	4. Soc. Sec. No							
	553. 655.116.							
5. Date of Birth	(Attach birth certificate)							
<b>ELIGIBILITY FOR</b>	DISTR	IRUTION						
LLIGIBILITITOR	DIOTIN							
	_							
6. Check One:	Ш	Normal Retirement (Age 62+)						
		I am retired under the Northern California Plastering Industry Pension Pension Plan						
		rension rian						
		F   D ('						
	☐ Early Retirement (Ages 55-62)							
	I am retired under the Northern California Plastering Industry Pension Plan							
		r ension rian						
	Disability Retirement							
		(Attach copy of Social Security Disability Award)						
	<ul> <li>I have not performed any work of the type covered under the Collective Bargaining Agreement for a total of six years and I do not hold a contractors license that would allow me to work in the plastering trade.</li> <li>The last date I worked in the plastering industry was:</li> </ul>							
		<u> </u>						
Do you currently ha	ve an a	ctive or inactive contractor's license?						

LAST EMPLOYER					
7. Date You Last Worked	_				
8. Name of Last Employer	_				
9. Address of Last Employer	<u> </u>	No. and Street			
	ō	City			State Zip Code
MARITAL STATUS					
10. Current Marital Status (Check One):			Never Married		Married (See 11.)
			Separated		Divorced (See 12.)
			Widowed (Attac	ch copy	y of death certificate)
11. If You Are Married, Provide the Spouse's Name Spouse's Address	e Follov		n About Your Sp	oouse:	
С	ity		;	State	Zip Code
Spouse's Soc. Sec. No					
Spouse's Date of Birth	(Attach birth certificate)				
Date of Marriage	e (Attach marriage license)				
12. Have you ever been divorced? (Answer even if you are not cu  If you were previously marrie Judgment of Dissolution of I Failure to provide these doc	rrently o ed, atta Marriag	divorced) ch a complete e, and propert	y settlement ag	erlocu jreeme	itory and/or Final ent, for each divorce.
I was previously married during	g years	that I participate	ed in the Plan.	□ Y	∕es □ No

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#### **EXPLANATION OF FORMS OF DISTRIBUTION**

Your Defined Contribution Plan offers the following forms of distribution:

**LUMP SUM DISTRIBUTION.** A Total or Partial Lump Sum distribution is available if you are totally and permanently disabled and have been granted an award of disability by Social Security, or if you have retired under the Northern California Plastering Industry Pension Plan under either Normal or Early Retirement.

**MONTHLY INSTALLMENTS.** Monthly Installments are available payable over your life expectancy or the life expectancy of you and your designated beneficiary in an amount not less that \$200 per month or more than \$10,000 per month (unless your life expectancy calls for a greater amount). However, if your monthly installments are eligible rollover distributions and you elect not to roll your monthly installments over into a qualified individual retirement arrangement or other qualified plan, the maximum monthly installment is \$3,125.

**COMBINATION PAYMENT.** If you are eligible to elect a lump-sum payment, you may also elect to receive a combination of partial lump and monthly installments.

# **ELECTION OF FORM OF DISTRIBUTION**

Beneficiary's Soc. Sec. No.

Employee's Signature:

13. I agree to be bound by the rules and regulations of the Defined Contribution Plan. I understand that I must personally endorse each benefit check. I hereby request distribution of my Defined Contribution Plan account in the form of distribution checked below. I have read the foregoing Explanation of Forms of Distribution and understand the effect of electing the form of distribution I have chosen below. ☐ Lump Sum Distribution in the amount of \$ Check One: ☐ Equal Monthly Installments in the amount of \$\_\_\_\_\_ ☐ Combination Payment – Partial lump-sum \$ followed by Monthly installments of \$\_\_ Employee's Signature: \_\_\_\_\_ Date \_\_\_\_ **DESIGNATION OF BENEFICIARY** 14. I hereby designate the following person to be the beneficiary of any benefits payable after my death under the option checked above, revoking all prior designations. ☐ My Spouse: (Fill in Name) Check One: ☐ Other Beneficiary as Indicated Below: Beneficiary's Name Beneficiary's Address No. and Street City State Zip Code

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\_\_\_\_\_ Date \_\_\_\_

### **CONSENT OF SPOUSE**

this beneficiary only until my spouse receives the first check from the Defined Contribution Plan, and that any withdrawal of my consent must be in writing and delivered to the Plan Administration Office prior to payment of the first check. ☐ I hereby consent to my spouse's designation of the following beneficiary: Spouse's Signature: Date State of California County of \_\_\_\_\_ On\_\_\_\_\_before me, \_\_\_\_\_ personally appeared\_\_\_\_\_ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the persons(s) or entity upon behalf of which the person(s) acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct. WITNESS my hand and official seal. Signature\_\_\_\_\_ Place Notary Seal Above Notary

15. I have read the foregoing and I understand my spouse may not name anyone other than me as beneficiary, unless I give my consent by signing below. I understand that I can withdraw my consent to

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### NOTICE OF WITHHOLDING FEDERAL AND STATE TAX

Payments from the Defined Contribution Plan are subject to Federal and State income tax withholding. If this distribution is an eligible rollover distribution then it is required by law that 20% is withheld for Federal Income Tax Withholding if you do not elect to rollover this distribution.

To elect not to have tax withheld, other than what is required by law, check the appropriate box and sign the Declaration below. To have income tax withheld by the Plan in addition to any required by law, check the appropriate box below.

# **DECLARATION REGARDING WITHHOLDING**

16. <b>FEDERAL</b>	TAX						
	I do not want income tax withheld from my Defined Contribution Plan payments.						
	I want income tax withheld from my Defined Contribution Plan payments.						
Employee's Sig	nature:	Date					
Spouse's Signa	ature:	Date					
17. STATE TA	x						
	I do not want income tax withheld from my Defined Contribution Plan payments.						
	I want income tax withhe	eld from my Defined Contribution Plan					
Employee's Sig	nature:	Date					
Spouse's Signature:		Date					
VERIFICATI	ON AND SIGNATUR	E					
the statements knowledge. I ur	on the attached pages an nderstand that a false stat	ury, that all of the above statements or d documents are true, correct and con ement may disqualify me for distributi nade to me because of a false stateme	nplete, to the best of my on and that the Trustees				
S	ignature of Employee	<del></del>	Date				

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