Northern California Plasterers Trust Funds
Health & Welfare Trust Fund, Pension Plan and Plasterers Local 66 Supplemental Pension Trust
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NORTHERN CALIFORNIA PLASTERERS PLAN TEMPORARY COVID -19 HARDSHIP APPLICATION

Applicant's Name:		SSN:
Address:		
Phone Number:	Email:	Date of Birth:

MARITAL STATUS

- ☐ Never Married
- ☐ Married — Date of Marriage _____ Name of Spouse _____
- ☐ Divorced — Date of Divorce _____
- ☐ Divorced & Remarried — Date of Divorce _____ Date of Remarriage _____
- ☐ Widowed

In connection with the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") which was signed into law on March 27, 2020, the Board of Trustees has approved changes to the Plan to allow qualified participants to take a one-time distribution through December 31, 2020 from their Plan account up to 100% of their account balance or $20,000, whichever is less.

In order to qualify for the distribution, the participant must meet one of the following criteria:

1. Be diagnosed with the COVID-19 virus by a test approved by the CDC; or

2. Have a spouse or dependent who is diagnosed with the virus by a test approved by the CDC; or

3. Experience adverse financial consequences as a result of being quarantined, being furloughed or laid off or having work hours reduced, be unable to work due to lack of child care, or close or reduce hours of their owned or operated personal business due to the virus, or other factors as determined by the Secretary of Treasury. For participants who qualify based on furlough or layoff, the Fund Office will verify their status with the Local Union through the out-of-work list.

This distribution is subject to ordinary income tax but is not subject to the early withdrawal penalty of 10%, which generally applies to participants under age $59^1/_2$. Further, since this distribution is not treated as eligible rollover distribution, it is not subject to the mandatory 20% tax withholding. However, 10% federal income tax withholding is applicable, **unless the participant waives the withholding.**

Under the CARES Act, you can spread out the taxes on the distribution ratably over a three-taxable-year period, beginning with the taxable year in which the distribution is made (unless you elect otherwise). You also can repay to the Plan the distribution amount at any time during the three-year-period beginning on the day after the distribution was received.

(Please complete the reverse side of this form)

PAYMENT REQUEST

Self-Attestation:

I hereby apply for benefits from the Plasterers Local No. 66 Supplemental Pension Plan and certify that I qualify for this distribution as a result of the following:

☐ I have been diagnosed with COVID-19

☐ I am caring for Spouse or dependent diagnosed with COVID-19

☐ I have experienced adverse financial consequences as a result of 1) being quarantined; 2) being furloughed or laid off or having work hours reduced, be unable to work due to lack of childcare, or close or reduce hours of their owned or operated personal business due to the virus, or other factors as determined by the Secretary of Treasury.

☐ **I would like to request a onetime payment in the amount of (cannot exceed $20,000)**

Total Amount Requested $ _____

The distribution you will receive is subject to federal and state income taxes. Federal income taxes **will** be withheld from your distribution (default is 10%), unless you elect out of withholding. Whether or not you choose to have federal and state income taxes withheld, you are liable for payment of federal or state tax on the taxable portion of your distribution. Please make your elections below.

FEDERAL INCOME TAXES (check one):

☐ I do not want federal income taxes withheld from my distribution.

☐ I want federal income taxes withheld from my distribution. 10% will be withheld.

STATE INCOME TAXES (check one):

☐ I do not want California state income taxes withheld from my distribution.

☐ I want California state income taxes withheld in the amount of _____

The above statements are true to the best of my knowledge and belief. I understand that a false statement may disqualify me for Supplemental Plan benefits and that the Board of Trustees shall have the right to recover any payments made to me because of a false statement. I acknowledge that I have read the Plan Rules and Regulations and that any questions I have concerning them have been answered.

Print full Name:	SSN:
Signature: _____	Date: