Northern California Plasterers Trust Funds
Health and Welfare Trust Fund, Pension Plan, and Plasterers Supplemental Pension Trust
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PLASTERERS UNION LOCAL 66 SUPPLEMENTAL RETIREMENT BENEFIT PLAN
ALTERNATE PAYEE BENEFIT APPLICATION

INSTRUCTIONS

- Please read and complete each section carefully.
- Print or type your answers (except signatures).
- Sign and date the Application.
- Please submit copy of Death Certificate.
- 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.

PERSONAL DATA – EMPLOYEE (Participant)

1. Name _____
   Last First Middle
2. Address _____
   No. and Street
   _____
   City State Zip Code
3. Telephone No. _____ 4. Soc. Sec. No. _____
5. Date of Birth _____
6. Date of Death _____

PERSONAL DATA – ALTERNATE PAYEE

7. Name _____
   Last First Middle
8. Address _____
   No. and Street
   _____
   City State Zip Code
9. Telephone No. _____ 10. Soc. Sec. No. _____
11. Date of Birth _____
12. Relationship to Employee _____ 13. If Spouse: Date of Marriage _____

BENEFIT PAYMENT FORM

14. I desire receipt of my survivor benefit in the following form:

Check One: ☐ **Lump Sum**

☐ **Rollover**

☐ **Monthly Payments – Amount _____ per month**

The administration office may request additional documents in order to complete your application.

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

15. **FEDERAL INCOME TAXES (check one):**

☐ I do not want income tax withheld from my Defined Contribution Plan payments.

☐ I want income tax withheld from my Defined Contribution Plan payments.

Signature: _____ Date _____

16. **STATE INCOME TAXES (check one):**

☐ I do not want income tax withheld from my Defined Contribution Plan payments.

☐ I want income tax withheld from my Defined Contribution Plan.

Signature: _____ Date _____

VERIFICATION AND SIGNATURE

17. I hereby certify, under penalty of perjury, that all the above statements on this Application and all the statements on the attached pages and documents are true, correct, and complete, to the best of my knowledge. I understand that a false statement may disqualify me for distribution and that the Trustees have the right to recover any payments made to me because of a false statement.

Signature: _____ Date _____