FOX VALLEY & VICINITY LABORERS

HEALTH AND WELFARE AND PENSION FUNDS

NEW PROCEDURE BEGINNING 2025

DATE: January 20, 2025

TO: Retirees and Beneficiaries of the
Fox Valley and Vicinity Laborers Pension Fund

SUBJECT: Annual Certification Information Form and
Suspension of Benefit Information

Annually, as a retiree or beneficiary you must provide evidence of existence that you are eligible to receive a benefit and that your benefit is being directly deposited into your account or your check is being properly endorsed by you. Additionally, the Fox Valley and Vicinity Laborers Pension Fund is required to notify all retirees about the rules regarding suspension of benefits.

2025 Annual Certification Information Form:
Please complete and return the enclosed Annual Certification Information Form by April 15, 2025. **As a retired laborer, it is necessary for you to submit a copy of your 2024 personal income tax return and all W-2 wage and tax statements and/or 1099-MISC/NEC forms to support the Income on line 1a Total amount from Form(s) W-2. Only page one of your Form 1040, and Schedule C (Form 1040), if applicable, is required. Please note this information will remain confidential and only be used for determining the continuation of your pension benefits.**

The certification information form must be signed by you and your signature be witnessed and signed by a Notary Public, your Local Union Business Agent, or by a Plan Representative at the Fund Office. Please note that the witness or notary cannot be a relative.

The completed form and supporting documentation may be returned in person, via fax at (847) 742-4430, via email at pension@fvlab.com, or via mail in the enclosed self-addressed return envelope.

FAILURE TO RETURN YOUR ANNUAL CERTIFICATION INFORMATION FORM BY APRIL 15, 2025 MAY RESULT IN A DELAY OF FUTURE BENEFIT PAYMENTS

2371 Bowes Road, Suite 500; Elgin, Illinois 60123-5523
Toll Free (866) 828-0900 Office (847) 742-0900 Fax (847) 742-4430
www.fvlab.com

January 20, 2025

Suspension of Benefit Information:
Retirees are required to notify the Fund Office within 30 days after returning to work. This includes working in self-employment or employment for a non-contributing employer. Your benefit may be suspended, regardless of the employer, if it is determined that you are working in Disqualifying Employment as described in the "Return to Work Packet" which is available on our website at www.fvlab.com on the Forms or Pension pages or upon request from the Fund Office.

Please contact the Pension Department at the Fund Office before returning to work to request an advance determination as to whether a particular job will cause your benefit to be suspended.
(Note: Benefits will not be suspended if you are over age 73 and continue to work.)

If you return to work in Disqualifying Employment:

1. You must notify the Fund Office in writing regardless of the number of hours worked per month.
2. Your pension benefit (and welfare benefit, if applicable, beginning June 1, 2025) will be suspended for any month in which you work 40 or more hours per month in Disqualifying Employment. This includes work in the same industry, trade or craft, and geographic area.
3. You must notify the Fund Office in writing when you stop working so that your benefit can be resumed.
4. You are liable for repayment to the Pension Fund for any benefits paid to you if you were working 40 or more hours per month in Disqualifying Employment.

Your immediate attention to this matter is greatly appreciated. Please contact the Pension Department at (847) 742-0900 extension 104 if you have any questions.

Thank you for your cooperation.

Sincerely,

Board of Trustees
Fox Valley and Vicinity Laborers Pension Fund

Enclosures

Fox Valley and Vicinity Laborers Pension Fund
2025 Annual Certification Information

2371 Bowes Road, Suite 500; Elgin, IL 60123-5523

Email: pension@fvlab.com **Fax:** (847) 742-4430 **Phone:** (847) 742-0900 **www.fvlab.com**

• PENSION RECIPIENT *(please print clearly)*

(Including a widow, a beneficiary, a disability, an ex-spouse collecting under a QDRO, a legal guardian, or an approved Power of Attorney)

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ FVL ID Number or Social Security Number: _____

☐ *Please check this box if your address or phone number has changed in the last year.*

• COMPLETE A or B

A. TO BE COMPLETED BY LABORER PENSION RECIPIENT:

2024 Income from IRS Form 1040 Line 1a: $_____**

YES	NO	
☐	☐	1. I am receiving my monthly benefit payments.
☐	☐	2. I have read and understand the rules regarding the Suspension of Benefits.
☐	☐	3. I am gainfully employed* (full-time or part-time). ***If YES, you must also complete the back side of this form.***

**This includes self-employment or employment for a non-contributing employer.*
If you are not sure whether a particular job will cause your benefit to be suspended, please contact the Fund Office IMMEDIATELY at (847) 742-0900, extension 104.

***Be sure to include supporting documentation, including all W-2 wage and tax statements and/or 1099-MISC/NEC forms and page one of your IRS Form 1040, and Schedule C (Form 1040) if applicable.*

B. TO BE COMPLETED BY SURVIVING SPOUSE / OTHER PENSION RECIPIENT

☐ **YES,** I am receiving monthly benefit payments. ☐ **NO,** I am not receiving monthly benefit payments.

• YOUR SIGNATURE MUST BE WITNESSED BELOW:

Signature: _____ **Date:** _____

SUBSCRIBED AND SWORN to before me this _____ day of _____ , 2025

Notary Public *(Signature)*

OR

WITNESSED by me this _____ day of _____ , 2025

Union Business Agent or Fund Representative *(Signature)*

Notary Seal Below

PLEASE IMMEDIATELY RETURN THIS FORM TO:

- Fox Valley and Vicinity Laborers Pension Fund
  2371 Bowes Road, Suite 500
  Elgin, Illinois 60123-5523
- **FAX:** (847) 742-4430 / • **EMAIL:** pension@fvlab.com

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RETURN TO WORK FORM

Failure to notify the Fund Office may result in a suspension of your pension payment.

A retiree is required to notify the Fund Office within 30 days upon returning to work, regardless of the number of hours worked or place of employment.

NAME: _____

ADDRESS: _____

SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

JOB TITLE: _____

JOB DESCRIPTION/DUTIES*: _____

DATE WORK WILL BEGIN: _____

EXPECTED WAGE/SALARY: _____

****A JOB DESCRIPTION FROM THE EMPLOYER MUST BE ATTACHED***

WILL YOU BE PERFORMING WORK AS A:

SUPERINTENDENT:	☐ YES	☐ NO
SUPERVISOR:	☐ YES	☐ NO
PROJECT MANAGER:	☐ YES	☐ NO

Number of hours you will be working per month. (Check one)

☐ Under 10 ☐ 26-39 ☐ 11-25 ☐ 40 or more

Participant's Signature: _____ Date: _____

Fund Office use only:

☐ Approved ☐ Denied Reviewed By: _____ Date: _____