HEALTH AND WELFARE AND PENSION FUNDS

Subject: Fox Valley & Vicinity Laborers Pension Fund
Pension Application Package

BOARDS OF TRUSTEES

WELFARE FUND

Employer Trustees

John P. Bryan, Secretary
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PENSION FUND

Employer Trustees

John P. Bryan, Secretary
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Martin D. Dwyer

Dear Participant:

Enclosed please find a pension benefit application and other related forms and information. Please review them carefully before completing.

TO APPLY IN PERSON:

You must ***schedule an appointment*** with the Fund Office ***at least 60 days prior to the date you want your pension to begin***. You must bring your completed application, including the requested information at the time of your appointment.

TO APPLY BY MAIL:

Mail your completed application including the requested information ***at least sixty days prior to the date you want your pension payment to begin***. You will be notified if additional information is necessary.

Your benefit will be effective the first day of the month following receipt of your completed application or later if requested.

If you have any questions, please contact the Fund Office.

Sincerely,

Pension Department

2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523
(847) 742-0900 FAX (847) 742-3440 TOLL FREE (866) 828-0900
www.fvlab.com

GCC/IBT 1317-M

FOX VALLEY & VICINITY LABORERS PENSION FUND

NOTICE TO PARTICIPANTS REGARDING YOUR PENSION APPLICATION

Please read this notice carefully. It contains important information regarding your application for benefits from the Fox Valley & Vicinity Laborers Pension Fund.

Proof of age – You must provide proof of your age when you apply for a pension benefit. If you are applying for a Survivor Benefit your spouse must also provide proof of age. Proof of age is required so that your benefit is accurately calculated. A copy of your birth certificate is the best document for proof of age. If you do not have your birth certificate, you may submit a baptismal certificate or statement as to the date of birth from a church record, notification of registration of birth in a public registry of vital statistics, certification of record of age by the U.S. Census Bureau, or a hospital birth record.

If you cannot provide any one of the above records please contact the Administrative Office for a list of other acceptable documents to prove your age. Please note that all foreign documents should be accompanied by a notarized English translation.

Income Tax Withholding – You must complete the attached Withholding Certificate for Pension or Annuity Payment form (W4P). This form allows you to request income tax to be withheld from your monthly benefit. Your benefit cannot be paid until the Administrative Office has a signed W4P on file.

Normally, the State of Illinois does not tax distributions received from qualified employee benefit plans.

Please discuss all tax issues with your tax advisor.

Suspension of Benefits – Once you retire and begin to receive a monthly pension benefit, your monthly benefit will be suspended if you engage in "Disqualifying Employment." Your monthly pension benefit will be suspended one month for each month in which you work 40 or more hours in "Disqualifying Employment." "Disqualifying Employment" is employment in the same Industry, Trade or Craft, and Geographic Area. All paid time shall be considered toward the 40 hours, even if the compensation is for vacation, illness or other incapacity.

"Industry" is defined as the construction industry or any other industry in which employees covered by the Plan had been employed when the participant's pension began.

"Trade or Craft" is defined as a job or occupation in which you use the same skill or skills that you used while in employment under the Plan.

"Geographic Area" is defined as the State of Illinois and/or any other area covered by the Plan when the retiree's pension began. "Geographic Area" also includes any area covered by a reciprocal agreement with the Plan.

Please note that a benefit may be suspended regardless of the employer, if the retiree works in Disqualifying Employment. This means that even if a retiree returns to work for a non-contributing employer, or is self-employed, the pension benefit is subject to the suspension rules.

Contiguous Non-Covered Service – If you work for the same employer in a position that does not require contributions to the Fund immediately before or after you work for the same employer in Covered Service, you may qualify to receive additional service credits. Service credits are used solely for vesting purposes.

Pro Rata Pension – You may be eligible for a pro rata pension if you have earned years of service with various pension funds. To be eligible for a pro rata pension you must have earned at least one year of credited service with one or more funds signatory to the Laborers International Pro Rata Agreement. If contributions were remitted to several pension funds please list each fund by name on the application.

Normal Forms of Benefit Payment - The normal form of benefit payment for any Participant is determined by the Participant's marital status at the time benefit payments commence. Unless you elect an optional form of benefit payment, your benefit will be paid in the normal form that is applicable to your marital status, as described below.

Life Annuity - If you are not married at the time your benefit payments commence, your benefits will be paid in the form of a Life Annuity, unless you elect otherwise. A Life Annuity is a series of level monthly benefit payments continuing for your lifetime only, with all benefit payments ending upon your death.

Joint and 50% Survivor Benefit with Pop-up - If you are married at the time your benefit payments commence, your benefits will automatically be paid in the form of a Joint and 50% Survivor Benefit with Pop Up, unless you elect a different form of a benefit. This option provides reduced monthly benefits during your lifetime, with 50% of your monthly benefit continuing to be paid to your spouse for the remainder of his or her lifetime upon your death. If your spouse dies before you do, your monthly benefit will return to the Life Annuity amount for payments made after his or her death. The benefit is reduced from the Life Annuity because payment will be made over two life expectancies (for you and your spouse). The reduction also takes into account the possibility that the annuity may be increased if your spouse predeceases you.

Spousal consent. If you are married and do not want to receive your benefits in the Joint and 50% Survivor Benefit with Pop Up form, you must obtain your spouse's consent to elect a different form. The consent must be in writing and it must be witnessed by a trustee's representative or a Notary Public.

Optional Forms of Benefit Payment - The Plan provides several optional forms of payment that you may select instead of the normal forms. In addition to the optional forms listed below, a married Participant may elect (with spousal consent) to have his or her benefit paid as a Life Annuity. When you are reviewing these options, please note that not all options are available to Participants who are not married.

Joint and 50% Survivor Option - This option provides a reduced monthly benefit during your lifetime, with 50% of your reduced monthly benefit continuing to be paid upon your death to your spouse, for the remainder of his or her lifetime. The benefit is reduced from the Life Annuity because payment will be made over two life expectancies (for you and your spouse). You need to provide written spousal consent to elect this form of benefit payment. This option is available only to Participants who are married.

Joint and 75% Survivor Option - This option provides a reduced monthly benefit during your lifetime, with 75% of your reduced monthly benefit continuing to be paid upon your death to your spouse, for the remainder of his or her lifetime. The benefit is reduced from the Life Annuity because payment will be made over two life expectancies (for you and your spouse). You need to provide written spousal consent to elect this form of benefit payment. This option is available only to Participants who are married.

Joint and 75% Survivor Option with Pop-up - This option provides a reduced monthly benefit during your lifetime, with 75% of your reduced monthly benefit continuing to be paid upon your death to your spouse, for the remainder of his or her lifetime. If your spouse dies before you do, your monthly benefit will return to the Life Annuity amount for payments made after his or her death. The benefit is reduced from the Life Annuity because payment will be made over two life expectancies (for you and your spouse). The reduction also takes into account the possibility that the annuity may be increased if your spouse predeceases you. You need to provide written spousal consent to elect this form of benefit payment. This option is available only to Participants who are married.

Joint and 100% Survivor Option - This option provides a reduced monthly benefit during your lifetime, with 100% of your reduced monthly benefit continuing to be paid upon your death to your spouse, for the remainder of his or her lifetime. The benefit is reduced from the Life Annuity because payment will be made

over two life expectancies (for you and your spouse). You need to provide written spousal consent to elect this form of benefit payment. This option is available only to Participants who are married.

Joint and 100% Survivor Option with Pop-up - This option provides a reduced monthly benefit during your lifetime, with 100% of your reduced monthly benefit continuing to be paid upon your death to your spouse, for the remainder of his or her lifetime. If your spouse dies before you do, your monthly benefit will return to the Life Annuity amount for payments made after his or her death. The benefit is reduced from the Life Annuity because payment will be made over two life expectancies (for you and your spouse). The reduction also takes into account the possibility that the annuity may be increased if your spouse predeceases you. You need to provide written spousal consent to elect this form of benefit payment. This option is available only to Participants who are married.

Five-Year Certain and Life Option - This option provides a reduced monthly benefit for your lifetime, with a minimum guaranteed period during which benefit payments will be made equal to five years (60 months). If you die before the guaranteed period ends, your spouse or other designated beneficiary will receive monthly benefit payments for the remainder of the guaranteed period you elected. If you live longer than the guaranteed period, the benefit payments will continue for your lifetime and cease upon your death. The benefit is reduced from the Life Annuity to take into account the guarantee of at least 60 monthly benefit payments. If you are married, you will need to provide written spousal consent to elect this form of benefit payment.

Ten-Year Certain and Life Option - This option provides a reduced monthly benefit for your lifetime, with a minimum guaranteed period during which benefit payments will be made equal to ten years (120 months). If you die before the guaranteed period ends, your spouse or other designated beneficiary will receive monthly benefit payments for the remainder of the guaranteed period you elected. If you live longer than the guaranteed period, the benefit payments will continue for your lifetime and cease upon your death. The benefit is reduced from the Life Annuity to take into account the guarantee of at least 120 monthly benefit payments. If you are married, you will need to provide written spousal consent to elect this form of benefit payment.

Level Income Option - This option provides an increased monthly benefit for payments made before you attain age sixty-two (62) or sixty-five (65) (depending on the age you expect to begin to receive Social Security benefits) and a reduced monthly benefit after you attain that age. This form of payment is intended to provide, to the extent possible, an aggregate income from the Plan and Social Security that is approximately level for your life. Payments will end upon your death. If you are married, you will need to provide written spousal consent to elect this form of benefit payment.

Lump Sum Up to $5,000 (but greater than $1,000) Option – If the total present value of your vested accrued benefit is $5,000 or less (but greater than $1,000), you may elect a lump sum payment of such amount. No additional payments will be made. You do not need to provide written spousal consent to elect this form of benefit payment. You will be notified if you are eligible for this form of payment.

Relative Value Comparison – This quotation of benefits is intended to provide information you need to decide which form of benefit payment is the best for you. A relative value comparison is included to allow you to compare the total value of benefits payable in the different forms. This quotation of benefits is also intended to disclose the financial effect of electing any of the various forms of benefit that may be available to you. The dollar amount of your monthly benefit under each optional form (and the amount your beneficiary will receive, if applicable) is included in this quotation of benefits. You (and, if you are married, your spouse) should review all parts of your quotation of benefits carefully before making or consenting to any election.

The relative value comparison is made by converting the value of the optional forms of benefit presently available into a common form, the Life Annuity. The conversion uses the interest rate and life expectancy assumptions

described below. All comparisons are based on average life expectancies. The relative value of benefit payments ultimately made under an optional form of benefit payment will depend on actual longevity.

The relative value comparison for annuity forms of payment is determined on the basis of the following interest and life expectancy assumptions:

- Interest Rate: 7.5%
- Mortality Table: UP-1984

Based on the above assumptions, all annuity forms of payment have the same relative value as the Life Annuity.

This means that the amount of each periodic payment that you receive may be higher or lower than the amount of each periodic payment you would receive under another form of benefit payment. This adjustment to the amount of your periodic payments reflects the fact that your benefits are payable over a potentially longer or shorter period of time than under the normal form of benefit.

For example, let's say that you are entitled to a monthly benefit amount equal to $100. If your normal form of benefit payment is a Life Annuity, then you are entitled to $100 per month, starting on your normal retirement date and continuing for the rest of your life. However, if you are married, your benefit must be paid in the form of a Qualified Joint and Survivor Annuity, unless you elect otherwise with the consent of your spouse, as described earlier. Since a portion of your benefit will continue to be paid to your spouse if he or she survives you, your monthly benefit will be reduced to, say, about $90 during your lifetime, and then 50% of that reduced amount ($45 in this example) will be paid to your spouse if he or she survives you. The exact amount by which your benefit is actually reduced depends upon your age and your spouse's age when you retire.

The relative value of the lump sum payment, if applicable, is determined on the basis of the applicable interest rate and applicable mortality table currently provided by the Internal Revenue Code for lump sum payments as follows:

- Applicable Interest Rate: The annual yield for 30-year Treasury constant maturities as determined for the month of April immediately preceding the Plan Year in which the payment is made.

- Applicable Mortality Table: 1994 Group Annuity Reserving Table as revised by Revenue Ruling 2001-62.

Based on the above assumptions, the lump sum payment has the same relative value as the Life Annuity.

Please note that if a portion of your benefits is payable to an alternate payee under a Qualified Domestic Relations Order (QDRO), your benefit amount is adjusted to reflect the terms of the QDRO. Please confirm that the benefit amounts listed in this distribution packet reflect your understanding of the division of your benefit under the QDRO. If you have questions regarding the benefit amounts listed here, or about the application of the QDRO, please contact the Benefits Department.

Military Service – If you are absent from employment due to military service for the United States you can receive service credits for those years provided you return to work with a contributing employer within ninety days of your release.

Plan Representative – Some sections of the application require your election to be witnessed by a Plan Representative or a notary public. A Plan Representative is a pension representative in the Administrative Office. Therefore, these sections would need to be completed in the Administrative Office or else they must be notarized.

Direct Deposit of Pension Benefit Check – Your pension benefit check must be deposited directly to your bank instead of receiving a paper check each month. Advantages of direct deposit are, it saves you banking time

and effort, avoids postal delays, eliminates the danger of lost or stolen checks, and the security of knowing your check has been deposited while traveling. Please attach a copy of a voided check.

Retiree Welfare Program

Eligibility:

- Must be receiving a Pension Benefit from Fox Valley & Vicinity Laborers Pension Fund; and,
    - Must have 15 years of service under the Fox Valley & Vicinity Laborers Pension Fund; or,
    - Must have 15 years of service under the Fox Valley Laborers Health and Welfare Fund, and,
- Must have been eligible for welfare benefits for at least one Benefit Quarter within the last four quarters immediately before retirement; or,
- Must be receiving a 30 & Out pension and have at least 1,000 hours in the 4 contribution quarters immediately before retirement.

The following self-pay rates are based on:

- The age of the Retiree on the date of his retirement; and,
- The number of years of service with the Fox Valley & Vicinity Laborers Pension Fund.

Rates:	15-19 years	20-24 years	25-29 years	30+ years
Under age 65	$1,541/each	$308/each	$231/each	$154/each
Age 65+	$509/each	$102/each	$76/each	$51/each

Authorization To Withhold Medical self-payments – If you are eligible for senior member coverage under the Fox Valley Laborers Health and Welfare Fund, your medical insurance premium can usually be deducted from your pension benefit check. This form authorizes the Administrative Office to withhold 1/3 of the premium each month. However, the following requirement must be met:

a. Your pension check must be larger than your medical premium.
b. Deductions must begin three months prior to an eligibility quarter. For example, 1/3 of the premium will be withheld in February, March and April for medical coverage in April, May and June.
c. Deductions cannot begin mid-quarter.
d. This Authorization can only be changed in writing at the end of a benefit quarter by notifying the Administrative Office in writing thirty days prior to the change.

Benefit Freeze – A participant who discontinues employment with a contributing employer and works for a city, county, state, or national governmental body in a job classification normally covered by a collective bargaining agreement may be granted a leave of absence and a temporary waiver of the Service rules under the Plan. The following requirement must be met:

a. You must have earned at least one year of future service.
b. You apply for a benefit freeze.
c. The Board of Trustees approves your application.

During a benefit freeze a participant can neither earn nor forfeit service, and their right to receive benefits from the Plan shall be based on the eligibility status as of the date the Benefit Freeze was initially granted.

Death Benefit – A participant may be eligible for a $5,000 lump sum death benefit payable to the named beneficiary(ies) upon proof of death. A death certificate must be sent to the Administrative Office.

Effective Date – Your benefit will be effective the first of the month following receipt of your completed application.

Timing of Notice and Distribution: 30/90 Day Rules and Revocation

Under Federal guidelines, a period of at least 30 days must pass between the time when you and your spouse (if married) have received this Notice and the date when the Fund sends your first check. In addition, under those guidelines you must sign and return the Pension Application form (including the requested information) within 90 days after receiving this Notice. What this means is that you and your spouse have at least 30 days and no more than 90 days after receiving this Notice to make your form of benefit election and consent (if applicable).

Once your spouse has given written consent to any election you make, he or she cannot revoke that consent. However, you may change your form of benefit election at anytime prior to the date benefit payments begin, as long as your spouse provides a new written consent that indicates his or her approval of the new form of benefit you elected. Contact the Fund Office if you wish to change your election.

If you revoke your election, your new election must be returned within 90 days after receiving this Notice. If your new election is not made within this time frame, a new Notice will have to be provided, and a new 30/90 day period for making your election will begin.

For further information on these and other pension issues please refer to your Summary Plan Description booklet. If you have additional questions please call the Administrative Office at 847-742-0900.

FOX VALLEY & VICINITY LABORERS PENSION FUND

2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523
1-847-742-0900

PENSION APPLICATION

SECTION I. PARTICIPANT INFORMATION
Please complete Items 1, 2 and 3

1. PARTICIPANT INFORMATION:

Name of Participant: ______________________________

Address: ______________________________

Telephone: (____) ____________________ Local No.: ____________________

Social Security # ____________________ *(Please attach copy of card)* Date of Birth: ____________________ *(Please submit a copy of your birth certificate)*

Effective Date of Pension: ____________________ Membership Date: ____________________

Date Last Worked: ____________________ Date Last Worked in the Trade: ____________________

Name of Last Employer: ______________________________

Job Title: ______________________________

Participant's Signature: ______________________________ Date: ______________

2. BENEFIT TYPE (CHECK ONLY ONE):

- ☐ Normal Retirement
- ☐ Early Retirement (Requires 10 future service credits)
- ☐ 30-and-Out Retirement
- ☐ Vested Benefit
- ☐ Total and Permanent Disability (Requires 10 future service credits. Must attach the Physician's Medical Report form and/or Certificate of disability from Social Security Administration.)

I understand that the Total and Permanent Disability benefit will cease after 24 payments unless the Fund Office is provided with a Certificate of disability from the Social Security Administration.

Participant's Signature: ______________________________ Date: ______________

3. SPOUSAL INFORMATION (CHECK ALL THAT APPLY):

- ☐ I am married **(attach copy of marriage license, spouse's birth certificate & social security card)**.
- ☐ I have never been married.
- ☐ I am divorced **(attach a copy of the divorce decree).**
- ☐ I am separated **(attach a copy of the decree, if legally separated).**
- ☐ I am a widow/widower **(attach a copy of the spouse's death certificate).**
- ☐ I am remarried **(attach a copy of the divorce decree or copy of the spouse's death certificate).**

Spouse's Name: ______________________________

Spouse's Address: ______________________________

Spouse's Social Security No.: ____________________ Date of Birth: ____________________

FOX VALLEY & VICINITY LABORERS PENSION FUND

Pension Application

SECTION II. PARTICIPANT EMPLOYMENT INFORMATION
Please complete all answers to Questions 1 through 5

1. **Have contributions been remitted into other pension funds on your behalf? If yes, please list the names and addresses of the other funds. (You may qualify for a Pro Rata benefit.)**

   ☐ Yes ☐ No (Skip to Question 2.)

   Fund Name: ____________________ Address: ____________________________________

   Fund Name: ____________________ Address: ____________________________________

2. **Have you worked in Contiguous Non-Covered Service for an employer (worked for a signatory employer in a job not covered under the collective bargaining agreement immediately preceding or after the time you worked for the same employer in covered work)? If yes, please complete the following:**

   ☐ Yes ☐ No (Skip to Question 3.)

   Employer Name: ____

   Address: ____________________________________ Job Title: ________________________

3. **Have you missed employment due to military service and as a result not received pension credits? If yes, please list years and attach a copy of your discharge papers.**

   ☐ Yes ☐ No (Skip to Question 4.)

   Years: ________________________

4. **Have you been granted a benefit freeze? If yes, please the name of your employer and job title.**

   ☐ Yes ☐ No (Skip to Question 5.)

   Employer: ________________________ Job Title: ______________________________

5. **Do you understand that if and when you are awarded a benefit, you cannot work in covered employment in the same industry, trade, craft or geographical area of the Fund for 40 or more hours per month without incurring a suspension of your benefit?**

   ☐ Yes, I understand.

FOX VALLEY & VICINITY LABORERS PENSION FUND

Pension Application

SECTION III. JOINT AND SURVIVOR BENEFIT INFORMATION
Please complete Item 1 and Item 2 where applicable

1. ELECTION OF SURVIVOR BENEFIT (Check Only One)

Instructions: If you elect a Survivor Benefit you must ***attach a copy of your marriage certificate and a copy of your spouse's birth certificate*** and your spouse must sign 1B below to consent to the benefit election. The consent must be witnessed by a notary public or Plan representative. Once a benefit is paid your election cannot be changed under any circumstances.

A. ☐ Joint & 50% Survivor Benefit Automatic Pop Up Option

☐ Joint & 50% Survivor Benefit

☐ Joint & 75% Survivor Benefit ☐ Joint & 75% Survivor Benefit Pop Up Option

☐ Joint & 100% Survivor Benefit ☐ Joint & 100% Survivor Benefit Pop Up Option

☐ 5 Year Certain and Life Option ☐ 10 Year Certain and Life Option

☐ Level Income Option (No Survivor Benefit) ☐ Level Income Option (Survivor Benefit)

☐ Life Annuity (No Survivor Benefit) (If single, skip to Section 4. If married, complete 1B and 2.)

B. I hereby accept the above election.

Spouse's Signature: ______________________________ Date: ________________

Witnessed By Plan Representative: ____________________ Date: ________________

Notary Signature: ________________________________ Date: ________________

Notary Seal:

2. REJECTION OF JOINT AND SURVIVOR BENEFIT

Instructions: *If you elected not to receive a Survivor Benefit, you and your spouse must sign below.* Your spouse is hereby consenting to the fact that benefits will cease upon your death. The consent must be witnessed by a Plan representative or notary public.

A. I reject a Joint and Survivor form of benefit. I understand that in the event of my death, my spouse will not be entitled to any benefit under the Joint and Survivor option.

Participant's Signature: ____________________________ Date: ______________

B. I understand that by consenting to the rejection of a Joint and Survivor Benefit, my spouse will receive a monthly benefit until death; however upon my spouse's death I will not be entitled to any benefit under the Joint and Survivor option.

Spouse's Signature: ______________________________ Date: ________________

Witnessed By Plan Representative: ____________________ Date: ________________

Notary Signature: ________________________________ Date: ________________

Notary Seal:

FOX VALLEY & VICINITY LABORERS PENSION FUND

Pension Application

SECTION IV (A) BENEFICIARY DESIGNATION - POST RETIREMENT DEATH BENEFIT
Please complete Item 1 and Item 2 where applicable
(For Active Participants Only)

1. PRIMARY BENEFICIARY DESIGNATION

Instructions: If you name more than one beneficiary, include the percentage of the benefit that each beneficiary should receive. *The percentages must equal 100 percent.*

Name: ____

Address: ____

Relationship: ______________________ Percentage: ________________

Name: ____

Address: ____

Relationship: ______________________ Percentage: ________________

Participant's Signature: ___________________________ Date: ______________

2. MARRIED AND DESIGNATING A BENEFICIARY OTHER THAN YOUR SPOUSE.

Instructions: If you are married and wish to designate a beneficiary(ies) **other than your spouse**, your spouse must consent, in writing, to such designation and the consent *must be witnessed* by a Plan representative or notary public.

I acknowledge and consent to the above beneficiary(ies) as designated. I also understand that as a result of the above beneficiary(ies) designation, I am not entitled to any benefits, upon my spouse's death, under the Plan. I understand that by my signature I am waiving my right to benefits to which I am otherwise entitled by law.

Spouse's Name: ____

Spouse's Signature: ___________________________ Date: ______________________

Witnessed By Plan Representative: _______________ Date: ______________________

Notary Signature: ___________________________ Date: ______________________

Notary Seal:

FOX VALLEY & VICINITY LABORERS PENSION FUND
Pension Application

SECTION IV (B) (cont.) BENEFICIARY DESIGNATION – LUMP SUM DEATH BENEFIT
Please complete Item 3 and Item 4 where applicable
LIFE ONLY BENEFIT

3. PRIMARY BENEFICIARY DESIGNATION

Instructions: If you name more than one beneficiary, include the percentage of the benefit that each beneficiary should receive. *The percentages must equal 100 percent.*

Name: ______________________________

Address: ______________________________

Relationship: ______________ Percentage: ______________

Name: ______________________________

Address: ______________________________

Relationship: ______________ Percentage: ______________

Participant's Signature: ______________ Date: ______________

4. MARRIED AND DESIGNATING A BENEFICIARY OTHER THAN YOUR SPOUSE.

Instructions: If you are married and wish to designate a beneficiary(ies) **other than your spouse**, your spouse must consent, in writing, to such designation and the consent *must be witnessed* by a Plan representative or notary public.

I acknowledge and consent to the above beneficiary(ies) as designated. I also understand that as a result of the above beneficiary(ies) designation, I am not entitled to any benefits, upon my spouse's death, under the Plan. I understand that by my signature I am waiving my right to benefits to which I am otherwise entitled by law.

Spouse's Name: ______________________________

Spouse's Signature: ______________ Date: ______________

Witnessed By Plan Representative: ______________ Date: ______________

Notary Signature: ______________ Date: ______________

Notary Seal:

SECTION IV (C) (cont.) BENEFICIARY DESIGNATION

Please complete Item 1

5 YEAR OR 10 YEAR CERTAIN AND LIFE OPTION

1. BENEFICIARY DESIGNATION

Name: ____

Address: ____

Relationship: ______________________

Participant's Signature: __________________________ Date: ______________________

FOX VALLEY & VICINITY LABORERS PENSION FUND

SECTION V. DIRECT DEPOSIT AUTHORIZATION (MANDATORY)
Please complete Item 1.

1. PARTICIPANT AUTHORIZATION

Instructions: ***Please attach a copy of a voided check***

I authorize the Administrative Office to deposit my pension benefit check directly into my account as follows:

Bank Name: ______________________________ ☐ Checking or ☐ Savings

Bank Address: ____________________________ Account No.: ________________________

Bank Routing No.:_________________________ Bank Phone No.: ______________________

Participant's Signature: ___________________________ Date: _______________________

Participant's Social Security Number:________________

FUND OFFICE FAX: 1-847-742-4430

FOX VALLEY & VICINITY LABORERS PENSION FUND
Pension Application

SECTION VI (A) WITHHOLDING OF MEDICAL SELF PAYMENTS (OPTIONAL)
If you elect to have medical self-payments withheld please complete Item 1

1. AUTHORIZATION TO WITHHOLD Medical self-payments

Instructions: If you meet the qualifications as explained in the Notice to Participants and choose to have your medical self-payments withheld from your pension check please complete the information below.

I am applying for a pension benefit from the Fox Valley & Vicinity Laborers Pension Fund and will be eligible for retiree medical coverage. I voluntarily authorize the Administrative Office to withhold 1/3 of the applicable medical self-payments from my monthly pension benefit check and pay that amount to the Fox Valley Laborers Health & Welfare Fund.

I understand that this authorization shall remain in effect until written notice is received from me by the Fund Office revoking that authorization.

Participant's Signature: ______________________________ Date: ____________________

Participant's SS#___________________________________

FOX VALLEY & VICINITY LABORERS PENSION FUND
WELFARE WITHHOLDING SCHEDULE

PENSION CHECK	PAYS THIS QUARTER	MONTH COVERED FOR MEDICAL
AUGUST SEPTEMBER OCTOBER	OCTOBER	OCT, NOV, DEC
NOVEMBER DECEMBER JANUARY	JANUARY	JAN, FEB, MARCH
FEBRUARY MARCH APRIL	APRIL	APRIL, MAY, JUNE
MAY JUNE JULY	JULY	JULY, AUGUST, SEPT

The Pension Department will withhold ⅓ of the quarterly self payment from each monthly pension check to pay the quarterly self payment which will give you medical coverage for that quarter.

FOX VALLEY & VICINITY LABORERS PENSION FUND

Pension Application

SECTION VI (B) WITHHOLDING OF MEDICAL SELF PAYMENTS (OPTIONAL)
If you elect to have medical self-payments withheld please complete Item 1

APPLICATION FOR RETIREE BENEFITS AFTER JULY 1, 2001

Name:____

Address ____

Social Security No. ____________________ Telephone: ____________________

[ ] I Elect Coverage

[ ] I Do not Elect Coverage

[ ] Not Eligible for Coverage

I hereby make application for the Benefit Program checked below to be effective the first day of the Benefit Quarter next following: the effective date of my pension award, or loss of eligibility under a Welfare Plan (as an active employee), whichever shall last occur.

I understand that should I lose eligibility due to failure to remit timely premium payments, I shall not be permitted to reinstate my coverage.

______ Myself $__________

______ Spouse: ____________________ $__________
Name

______ Dependents: ____________________ $__________
Name

Number of Service Credits are __________

Total Amount due Monthly
(if withheld from Pension Check) $__________

Total Amount due Quarterly $__________

All quarterly payments must be received in the Administrative Office no later than the day preceding the first day of the Benefit Quarter for which coverage is effective.

Date: ____________________ Signature: ____________________________

FOX VALLEY LABORERS HEALTH AND WELFARE FUND
2371 Bowes Road, Suite 500, Elgin, Illinois 60123-5523
Phone 847-742-0900 • Fax 847-742-4430

To: Health and Welfare Participants

Subject: Other Insurance Statement

In order to ensure correct benefit determination, please verify whether other insurance coverage exists for you and your family members. Please complete this form and return it to the Fund Office.

Participant Name:______________________ SSN/FVL #:______________________

Is any member of your family covered by any other insurance plan or eligible for Medicare?

Name:__________ Relationship:__________ Birthdate:__________ No_____Yes ___

Name:__________ Relationship:__________ Birthdate:__________ No_____Yes ___

Name:__________ Relationship:__________ Birthdate:__________ No_____Yes ___

Name:__________ Relationship:__________ Birthdate:__________ No_____Yes ___

Name:__________ Relationship:__________ Birthdate:__________ No_____Yes ___

Name:__________ Relationship:__________ Birthdate:__________ No_____Yes ___

Please complete the following information for each family member who has or had other insurance. Use additional forms if necessary.

If no, list termination date of the other coverage (if applicable):
Name:__________ Termination Date: ____/____/____

If yes, complete the entire form, sign and date below.

Name: ______________________
Address: ______________________
Social security number: _____-____-_____ Birthdate: ____/____/____

If the other plan is for your spouse, does it cover your dependent children? Yes _____ No _____
If yes, list all family members covered by the other plan:

____

____

What type of coverage does the other plan provide? Circle one or more of the following:
Medical Dental Vision Prescription Drugs Other: __________

If any of the above coverage has terminated, list the type of coverage and its termination date:
____/____/____

Name and address of other insurance carrier: _

____

Effective date: ____/____/____ Group/Plan Number: __________

Primary Insured's Name ______________ Insured's Number_______

Participant Signature	Date	Spouse Signature	Date

PLEASE INCLUDE A COPY OF THE FRONT & BACK OF YOUR INSURANCE AND/OR MEDICARE CARD WHEN YOU RETURN THIS FORM.

It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse the Fox Valley Laborers Health and Welfare Fund for any money it was induced to pay as a result of the information I provided. Receipt of this form is not a guarantee of eligibility.

FOX VALLEY & VICINITY LABORERS PENSION FUND
Pension Application

VII. DISABILITY BENEFIT
Please have your physician complete Items 1 and 2

1. MEDICAL REPORT FOR A DISABILITY BENEFIT

Patient Name: ______________________ Social Security No.: ______________

Address: ____

A. I examined the patient on (date) __________ at (location) ______________

B. The nature of the disability is ______________________________________

C. The disability commenced on or about (date) ____________________________

D. I consider the probable future duration of the disability to be ______________

E. Based on my examination and conversation with the patient, it is my opinion that the disability: (Check the appropriate boxes)

☐ Was ☐ Was Not contracted, suffered or incurred while the employee was engaged in a criminal enterprise.

☐ Was ☐ Was Not as a result of addiction to narcotics.

☐ Was ☐ Was Not a result of an intentional self-inflicted injury.

☐ Was ☐ Was Not as a result from an injury, wound or disability incurred while serving in the Armed Forces of the United States or arising out of a state of war or civil unrest.

2. CERTIFICATION OF DISABILITY

Under the Pension Plan, "Permanent and Total Disability" means in part, total incapacity because of physical or mental condition so as to be prevented thereby from performing any duties for wage or remuneration.

I hereby certify that: (Please check one and complete as appropriate).

☐ I am of the opinion this applicant is Permanently & Totally disabled.

☐ I am of the opinion this applicant can engage in employment as follows:

____

Physician's Signature: ______________________________ Date: ______________

Printed Name: ____

Address: ______________________________ Telephone No: ______________

SUPPLEMENTAL LUMP SUM RETIREMENT BENEFIT ELECTION FORM

You are entitled to receive a Supplemental Lump Sum Retirement Benefit under the Fox Valley and Vicinity Laborers Pension Fund. You can delay payment of the Supplemental Lump Sum Retirement Benefit for up to 12 months after your retirement.

Distribution amount: $_______________________

____ I elect to take my distribution at this time.

____ I elect to defer my distribution at this time.

****

Print Name: ____

Signature: ____

Social Security #:___________________________Date:_______________________