FOX VALLEY & VICINITY LABORERS

HEALTH AND WELFARE AND PENSION FUNDS

IMPORTANT NOTICE

DATE: January 21, 2022

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 check is being properly endorsed by you or directly deposited into your account. Additionally, the Fox Valley and Vicinity Laborers Pension Fund is required to notify all retirees about the rules regarding suspension of benefits if you should return to work for 40 or more hours per month in Disqualifying Employment in the same industry, trade or craft, and geographic area.

2022 Annual Certification Information Form:

Please complete and return the enclosed Annual Certification Information Form by April 1, 2022. The completed form may be returned in person, via fax at (847) 742-4430, via email at customerservice@fvlab.com, or via mail in the enclosed self-addressed return envelope. **It is preferred that this form be signed by you and your signature be witnessed** and signed by a Notary Public, your Local Business Agent, or by a Plan Representative at the Fund Office. Please note that the witness cannot be a relative. ***However, due to the current conditions of the ongoing COVID-19 situation, the Fund Office will accept this form without a witness or notary's signature. Upon receipt of this form, your current signature will be compared to your signature on previous forms on file and the Fund Office will follow-up on any discrepancies.***

FAILURE TO RETURN YOUR ANNUAL CERTIFICATION INFORMATION FORM BY APRIL 1, 2022 MAY RESULT IN A DELAY OF FUTURE BENEFIT PAYMENTS

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 or not a particular job will cause your benefit to be suspended. (Note: Benefits will not be suspended if you are over age 72 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 benefit will be suspended for any month in which you work 40 or more hours per month in Disqualifying Employment.
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 Fund for any benefit 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. Thank you for your cooperation.

Sincerely,

Board of Trustees
Fox Valley and Vicinity Laborers Pension Fund

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

Fox Valley and Vicinity Laborers Pension Fund
2022 Annual Certification Information

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

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

Pension Recipient *(Please PRINT clearly)*

(including a widow, a beneficiary, 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.***

TO BE COMPLETED BY PENSION RECIPIENT:

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 complete both sides 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.*

TO BE COMPLETED BY "SURVIVING SPOUSE" ONLY:

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

Surviving Spouse: *(Please PRINT clearly)*

_____ _____

First Name Last Name

YOUR SIGNATURE MUST BE WITNESSED BELOW:

Signature: _____ **Date:** _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 2022

Notary Public *(Signature) Notary Seal Below*

OR

WITNESSED by me this _____ day of _____, 2022

Business Agent or Fund Representative *(Signature)*

PLEASE IMMEDIATELY RETURN THIS FORM TO:
Fox Valley and Vicinity Laborers Pension Fund
2371 Bowes Road, Suite 500
Elgin, Illinois 60123-5523
You may also **FAX TO**: (847) 742-4430
or **E-MAIL TO**: customerservice@fvlab.com

FOX VALLEY & VICINITY LABORERS

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

RETURN TO WORK FORM

Instructions: 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.

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

Please Complete Each Item *(Please PRINT clearly)*

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

JOB DESCRIPTION: _____

JOB DUTIES: _____

DATE WORK WILL BEGIN: _____

Please attach a copy of the job description from the employer (this is required).

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

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

Participant's Signature: _____

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Fund Office use only:

☐ Approved ☐ Denied Completed By: _____ Date: _____

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