**Laborers Annuity Plan for Northern California**
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

# BENEFIT APPLICATION

## INSTRUCTIONS

A. Read each question carefully and answer all applicable questions accurately to avoid delay in processing your application.
B. PRINT in ink or type all information.
C. Attach additional sheets if you need more space to answer any questions.
D. Be sure to sign and date the application – see PART E.
E. Mail completed application and proof of age to the Fund Office.

NO UNION, EMPLOYER OR OTHER OFFICE IS AUTHORIZED TO ACCEPT OR RECEIVE THE APPLICATION ON BEHALF OF THE FUND.

## PART A. PERSONAL DATA

| SOCIAL SECURITY NUMBER | NAME (LAST) | FIRST | MIDDLE |
|---|---|---|---|
| | | | |

| STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| DATE OF BIRTH<br>ATTACH PROOF OF AGE | LOCAL UNION NO. | TELEPHONE NO. |
|---|---|---|
| | | |

**MARITAL STATUS:** ☐ MARRIED (if YES, complete PRESENT SPOUSE information below) ☐ SINGLE

| PRESENT SPOUSE'S NAME | DATE OF BIRTH<br>ATTACH PROOF OF AGE | DATE OF MARRIAGE<br>ATTACH MARRIAGE CERTIFICATE |
|---|---|---|
| | | |

If you checked "MARRIED", were you legally married to anyone other than your present spouse on APRIL 1, 1985 or at any time thereafter? If you checked "SINGLE", were you ever legally married to anyone on APRIL 1, 1985 or at any time thereafter?

☐ **YES** (if YES, complete FORMER SPOUSE(S) information below for each marriage and attach copies of the Interlocutory and Final Judgment of Dissolution of Marriage and any other court order affecting your Annuity account. ☐ **NO**

| FORMER SPOUSE'S NAME | DATE OF MARRIAGE | DATE OF SEPARATION |
|---|---|---|
| | | |

## INSTRUCTIONS CONCERNING SUBMISSION OF PROOFS OF AGE

The acceptable proofs of your age are listed below in two groups. Submit a photocopy of one of the proofs listed in Group 1, if you have it, or can possibly obtain it, since this class of proof of age is more convincing.

If you cannot submit a proof in Group 1 classification, submit photocopies of two (2) of the proofs listed in Group 2. You are cautioned, however, that Naturalization Papers, United States Passports and Immigration Papers, MAY NOT BE PHOTOCOPIED. If you are submitting any of these, you must submit the original, it will be returned to you. Additional proofs of age may be requested if the documents you submit do not constitute convincing proof of your age.

### GROUP 1

1. A birth certificate.
2. A baptismal certificate or a statement as to the date of birth shown by a church records, certified by the custodian of such records.
3. Notification of registration of birth in public registry of vital statistics.
4. Certification of record of age by the U.S. Census Bureau.
5. Hospital birth records, certified by the custodian of such records.
6. A foreign church or government record.
7. A signed statement by the physician or midwife who was in a attendance at birth, as to the date of birth shown on their records.
8. Naturalization record. (Photocopy is not acceptable, submit original.)
9. Immigration papers. (Photocopy is not acceptable, submit original.)
10. Letter from Social Security Administration certifying to your age as it appears on their records.

### GROUP 2

11. Military record.
12. Passport. (Photocopy is not acceptable, submit original.)
13. School records, certified by the custodian of such record.
14. Vaccination record, certified by the custodian of such record.
15. An insurance policy which shows the age or date of birth.
16. Marriage records showing date of birth or age (application for marriage license or church record, certified by the custodian of such record, or marriage certificate).
17. Other evidence such as signed statements from persons who have knowledge of the date of birth.
18. Driver's License.

## PART B. RETIREMENT DATA

Check one of the following which applies to you and complete the information requested.

| | |
|---|---|
| 1. ☐ I am or will soon be receiving a pension from the Laborers Pension Trust Fund for Northern California. | DATE YOU RETIRED OR INTEND TO RETIRE : |
| 2. ☐ I am totally and permanently disabled and have established entitlement to a Social Security Disability Benefit. | DATE YOU BECAME DISABLED: |

NATURE OF DISABILITY: (Please attach a copy of Social Security Disability Certificate Award.)

3. ☐ I have attained age 65 and, to the best of my knowledge, no contributions to my Individual Account have been made for three consecutive months.

4. ☐ I have worked less than 500 hours for individual employers for which contributions were made or required to be made to my Individual Account in each of two consecutive calendar years.

5. ☐ I have worked less than 1000 hours for individual employers for which contributions were made or required to be made to my Individual Account in the 24-consecutive month period preceding the Annuity Starting Date.

| | |
|---|---|
| When did you last work in any employment for which contributions were made to the Plan on your behalf? : | Name of last contributing Individual Employer : |

Address of last contributing Individual Employer :

Name of present Employer (if any) :

Address of present Employer :

## PART C. PAYMENT OPTIONS

If you have been legally married throughout the one-year period ending on your annuity starting date, your accumulated share will be paid to you in the form of a joint and survivor annuity unless you elect to waive that form of annuity and your spouse has consented to such election. A qualified joint and survivor annuity continuing for the life of his spouse which is 50% or 75% of the annuity payable during the joint lives of the participant and his spouse. Please read and complete Part D of this form if it applies to you.

If you do not qualify for the joint and survivor annuity, or if you have elected to waive that form of benefit, with the consent of your spouse, your accumulated share may be paid to you in one of several forms. Please check your choice of payment form from the following options below. These amounts are estimates only and are intended to illustrate the relative value of annuity payments which you may receive so as to allow you and your spouse to make an informed decision with regard to your benefits under the Annuity Plan. If you elect option number 4 or 5, estimates will be provided after receipt of your election by the Fund Office.

1. ☐ LUMP SUM PAYMENT $**0.00** (Total account balance will be paid in a one-time lump sum payment.)
*** **A 20% Mandatory Federal Withholding** will apply to any payment greater than $199.99. The balance shown may not include interest yet to be applied to your Individual Account.

***If lump sum amount indicated above is less than $5,000.00, you do not need to complete PART D and have the application notarized. You will be paid a lump-sum benefit. If your benefit is $5,000.00 or more and you elected lump sum payment with the consent of your spouse, complete PART D and have the application notarized.***

2. ☐ SINGLE LIFE PENSION $_____ (Monthly benefit payable for your lifetime with remaining guaranteed payments to your beneficiary if you die before receiving 60 monthly payments.)

3. ☐ 50% JOINT & SURVIVOR PENSION **-OR -** ☐ 75% JOINT & SURVIVOR PENSION
$_____ Monthly benefit payable for your lifetime
$_____ Monthly benefit payable for your surviving spouse's lifetime, payable the month following your death

4. ☐ COMBINED ANNUITY AND LUMP SUM PAYMENT
LUMP SUM PAYMENT of $_____, and remainder of the account payable as a _____ annuity. (Indicate the amount of lump sum and payment option for the remainder of your account.)

5. ☐ TIME GUARANTEED LIFE ANNUITY
This form provides monthly payments beginning at retirement and continuing for the Participant's lifetime, with a minimum of 60, 120, or 180 monthly payments guaranteed. The smaller the minimum number of payments, the larger the monthly benefit.
☐ 60 PAYMENTS GUARANTEED ☐ 120 PAYMENTS GUARANTEED ☐ 180 PAYMENTS GUARANTEED

# PART D. QUALIFIED JOINT AND SURVIVOR ANNUITY
## WAIVER FORM

## Section I. EMPLOYEE'S STATEMENT

*I,_____, elect to waive my right to receive my annuity benefits in the form of a 50% annuity. I understand that my waiver of this form of annuity means no benefits will be paid to my spouse by the Annuity Plan after my death, except to the extent that the death benefits are payable under another option that I select.*

*I hereby declare under penalty of perjury under the laws of the State of California that:* ***(☐ check one)***

☐ **I have not** been legally married throughout the one-year period ending on my annuity starting date.
☐ **I have been** legally married, but I am unable to locate my spouse.
☐ The person signing this form below **has been** my legal spouse throughout the one-year period ending on my annuity starting date.

Employee's Social Security Number _____

Signature _____ Date _____

## Section II. SPOUSE'S STATEMENT

*I, _____, declare under penalty of perjury under the laws of the State of California that I have been the legal spouse of the employee named above throughout the one-year period ending on his/her annuity starting date. I hereby consent to my spouse's election to waive his/her right to receive his/her annuity benefits in the form of a 50% Qualified Joint and Survivor Annuity. I understand that as a result, I will not be paid an annuity from the Annuity Plan after my spouse's death, except to the extent of the death benefits payable under another option selected by my spouse. I further recognize that because of my spouse's election, the annuity paid to my spouse while he/she is living will be higher than it would be if I had the 50% survivor protection.*

Spouse's Social Security Number _____

Signature _____ Date _____

## Information Concerning the Survivor Spouse Annuity

**It is important that you understand that the following conditions apply when making the choice regarding the Qualified Joint and Survivor Annuity:**

1. If you elect the Qualified Joint and Survivor Annuity, your Individual Account will be used to buy an insurance contract to provide the lifetime annuity benefits that it pays. The level of monthly benefits depends on the market value of the amount in your account and insurance company annuity prices on the day the purchase is made.
2. The insurance company that issues the annuity contract will be solely responsible for paying all benefits due under it, and for all other matters of annuity contract interpretation and administration. The Annuity Plan will not pay any of the annuity benefits or be involved in administrative matters.
3. Your right and remedies, and those of your spouse, will be as spelled out in the insurance contract.

**THE BELOW CERTIFICATION MUST BE COMPLETED BY A NOTARY PUBLIC OR AN AUTHORIZED FUND REPRESENTATIVE BEFORE RETURNING THIS FORM TO THE FUND ONLY IF YOU HAVE COMPLETED PART D.**

On the _____ day of _____, _____ before me, ( A fund Representative), personally appeared _____, and _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the foregoing statement and acknowledged to me that (s)he/they executed the same.

_____
Fund Representative

**YOUR APPLICATION MUST BE SIGNED TO BE VALID**

## PART E. APPLICANT'S SIGNATURE

*I hereby apply for benefits from the Laborers Annuity Plan for Northern California. The above statements are true to the best of my knowledge and belief. I understand that a false statement may disqualify me for Annuity benefits, and that the Board of Trustees shall have the right to recover 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 had concerning them have been answered.*

**- - - PLEASE READ BEFORE YOU SIGN - - -**

BE ADVISED, YOUR ELECTED FORM OF PAYMENT IS FINAL UPON RECEIPT OF YOUR APPLICATION BY THE FUND OFFICE. **NO CHANGES CAN BE MADE TO YOUR ELECTION ONCE THE DISTRUBUTION HAS BEEN PROCESSED**. PLEASE BE SURE TO CHECK YOUR SELECTION BEFORE RETURNING THIS APPLICATION.

***Signature:*** ***Date:***

**YOUR APPLICATION WILL BE ACKNOWLEDGED AND YOU WILL BE NOTIFIED IN WRITING OF THE DECISION MADE BY THE BOARD OF TRUSTEES ON YOUR APPLICATION.**

**LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA**
**LABORERS VACATION-HOLIDAY TRUST FUND FOR NORTHERN CALIFORNIA**
**LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNIA**
**LABORERS ANNUITY PLAN FOR NORTHERN CALIFORNIA**
**220 Campus Lane, Fairfield, CA 94534-1498 * Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530**
E-Mail Address: customerservice@norcalaborers.org * Website: http://www.norcalaborers.org

# ENROLLMENT FORM

## Part I. PARTICIPANT INFORMATION (Please print clearly using ink pen)

| SOCIAL SECURITY NUMBER | NAME: FIRST MIDDLE LAST |
|---|---|
| | |

| MAILING ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| TELEPHONE NO. | E-MAIL ADDRESS, IF ANY | LOCAL UNION NO. | ☐ Cuando posible prefiero recibir información de beneficios en Español. |
|---|---|---|---|
| | | | |

| DATE OF BIRTH MONTH DAY YEAR | SEX | MARITAL STATUS MONTH DAY YEAR |
|---|---|---|
| / / | ☐MALE ☐FEMALE | ☐SINGLE ☐MARRIED – Give date of marriage: / / |

## Part II. DEPENDENT INFORMATION

IMPORTANT: List all "Eligible Dependents" to be enrolled in the Health and Welfare Plan. The term "Eligible Dependents" means your legal spouse, your children under age 26 regardless of marital status, and your unmarried children 26 of age or older who are totally handicapped as explained in the Plan. Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Fund Office to substantiate your relationship to your dependent(s):
SPOUSE – Marriage Certificate
NATURAL CHILD – Birth Certificate ADOPTED CHILD – Birth Certificate and Legal adoption document
STEP-CHILD – Birth Certificate
LEGAL GUARDIANSHIP – Guardianship papers or documents from a Court appointing you as the legal guardian
Write your social security number on each of the document(s) for identification purposes. Please notify or contact the Fund Office if documents are not available.
For Domestic Partner enrollment information, please read the reverse side for information and documents required.

| NAME - WRITE FIRST & MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM YOURS) | DATE OF BIRTH MONTH / DAY / YEAR | SOCIAL SECURITY NUMBER | DEPENDENT RELATIONSHIP |
|---|---|---|---|
| 1. | | | ☐SPOUSE ☐DOMESTIC PARTNER |
| 2. | | | ☐SON ☐DAUGHTER |
| 3. | | | ☐SON ☐DAUGHTER |
| 4. | | | ☐SON ☐DAUGHTER |
| 5. | | | ☐SON ☐DAUGHTER |



**This form will be returned if you fail to provide the dependent's date of birth and Social Security number.**

## Part III. BENEFICIARY INFORMATION - DESIGNATION OF BENEFICIARY

1.**Health and Welfare and Vacation-Holiday Trust Funds** – *You may designate any beneficiary you wish. Any benefits due from these Funds will be paid to your named beneficiary.*
2.**Pension Trust Fund and Annuity Plan** - If you are married, any benefits due will be paid to your surviving spouse, and not to your named beneficiary if not your spouse, in accordance with the provisions of the Pension and Annuity Plans. Contact the Fund Office or refer to your Plan booklets for more information regarding payment of benefits to beneficiary.
If you want to designate more than one person for one or more of the Funds, do not complete this section. Check-off this box ☐ to receive the appropriate form needed.

| SOCIAL SECURITY NUMBER | NAME: FIRST MIDDLE LAST | RELATIONSHIP |
|---|---|---|
| | | |

| MAILING ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

## Part IV. OTHER INSURANCE INFORMATION

Do any of your dependents listed on the reverse side of this form have another employer sponsored medical, prescription drug, dental and/or vision Plan coverage either as an employee or as a dependent? ☐No ☐Yes
If you answered "No", skip section IV. If you answered "Yes", fill in section IV. If you have more than one dependent who has another employer sponsored Plan, make a photocopy of section IV and complete the section for each dependent.

| Name of Insured or policy holder | Relationship to Participant |
|---|---|
| Social Security Number or ID number of Insured | Name of employer providing the coverage |

| TYPE OF BENEFITS PROVIDED | POLIGY NUMBER | EFFECTIVE DATE | DEPENDENTS COVERED? |
|---|---|---|---|
| NAME & ADDRESS OF MEDICAL PLAN | | | ☐ YES ☐ NO |
| NAME & ADDRESS OF DENTAL PLAN | | | ☐ YES ☐ NO |
| NAME & ADDRESS OF PRESCRIPTION DRUG PLAN | | | ☐ YES ☐ NO |
| NAME & ADDRESS OF VISION CARE PLAN | | | ☐ YES ☐ NO |

Not Applicable

## Part V. DOMESTIC PARTNER INFORMATION

In order to determine whether your Domestic Partner meets the Plan's requirement for Domestic Partner coverage, please furnish the information below. To enroll your Domestic Partner's children, if any, you must provide the applicable documents as listed in the Dependent Information section of this form.

A written statement from your employer certifying that the employer has a job contract with the City or County of San Francisco, City of Oakland, City of Sacramento, County of San Mateo or the State of California. If the employer has entered into a contract with the State of California, they must also certify that the cumulative amount of the contract is $100,000.00 or more during the State's fiscal year.

If your employer certifies that they are doing business with or have entered into a job contract with the City or County of San Francisco, City of Oakland or City of Sacramento, you must provide a copy of your Domestic Partner certificate issued by any city, county or state agency or,

If your employer certifies that they are doing business with or have entered into a job contract with the **County of San Mateo or the State of California**, you and your partner must be registered as domestic partners with the California **Secretary of State**, obtain a domestic partners certificate from the Secretary of State's office and provide a copy to the Fund office. Please be aware that the recently enacted Assembly Bill 17 applies to **County of San Mateo and the State of California.** AB 17 requires employers to provide benefits to **same-sex** partners only. There is an exception for opposite sex partners if either you are or your partner is over age 62.

## PARTICIPANT STATEMENT – You MUST date and sign form

***I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.***

DATE: SIGNATURE:

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# Rollover Election Form

**IMPORTANT**
**Before completing this form you should read the Special Tax Notice regarding Plan payments carefully. You also may wish to consult your tax advisor before making this election.**

Participant's Name/Surviving Spouse's Name

Social Security Number

Street Address

City State Zip Code

If you will receive part or all of your benefits as an "eligible rollover distribution," you may elect to have part or all of that distribution transferred directly to an Individual Retirement Account (IRA) or to another qualified retirement plan (if it accepts rollovers). If you choose **not** to have an eligible rollover distribution transferred directly to an IRA or other retirement plan, the Plan is required to withhold 20 percent of the payment for Federal Income tax. This withholding does not increase your taxes, but will be credited against any income tax you owe. (For further information on direct rollovers and withholding, please read the Special Tax Notice Regarding Plan Payments that the Plan has given you.)

Check below to indicate whether or not you elect a direct rollover of your pension payment:

○ I **DO NOT WANT** to roll over any of my payment to an IRA or other qualified retirement plan. Pay me the full amount of my benefits, after withholding applicable taxes.

**SIGNATURE** ☞ _____ **DATE** _____

○ I **WANT** to roll over my payment directly to an IRA or other qualified retirement plan that accepts rollovers. The IRA or other retirement plan is named on the reverse side.

○ I would like to have only **PART** of my payment directly rolled over. Please roll over $ _____ to the IRA or qualified retirement plan named on the reverse side, and pay the remainder of my benefit to me, after withholding applicable taxes.

**- continued on reverse side -**



## CERTIFICATION

If you have elected a direct rollover of all or part of your benefit, please read the following statement, provide all of the information, and sign below:

> I certify that the recipient of a direct rollover that I have named below is an Individual Retirement Account, an Individual Retirement Annuity, or a qualified retirement plan that accepts rollovers. I understand that payment of my benefits to the trustee of the IRA or qualified retirement plan will release the Trustees of the Laborers Annuity Plan for Northern California from any further obligations or responsibilities with respect to the benefits so paid.

Please make payment of my benefits on my behalf to:

**Name of IRA Trustee or Qualified Retirement Plan**

**Account Number**

**Mailing Address**

**City** **State** **Zip Code**

☞ _____

**Signature**

**Date**

**NO DIRECT ROLLOVER CAN BE MADE UNTIL YOU PROVIDE ALL OF THE INFORMATION REQUESTED ABOVE.**