SHEET METAL WORKERS' NATIONAL PENSION FUND

REACTIVATE APPLICATION FOR PENSION

PARTICIPANT: _____

ADDRESS: _____

_____

_____

_____

Local Union: ____ **Social Security Number:** *****____ **(enter last four digits only)**

EFFECTIVE DATE: _____

LAST DATE OF WORK: _____ **TELEPHONE NUMBER:** _____

CERTIFICATION, SIGNATURE AND DATE – By my signature, I certify that:

- I understand that my eligibility for benefits and the amount of my benefits are based on the accuracy of this application and other material and information I have provided to the Fund.
- ALL of the statements found in this application and in any other material I have submitted to the Fund are complete and accurate.
- The Trustees have the right to recover any payments made to me in error, or payments made because of any false or incorrect statements -- whether deliberate, or by accident, mistake or misunderstanding.
- I must notify the Pension Fund office of any change in my personal, marital or employment status.
- I agree to be bound by all Plan Rules and Regulations as a condition of receipt of benefits.

_____ _____

Signature of Applicant Date Signed

The Fund office will forward a letter within 3-4 weeks to acknowledge receipt of your request.

Note: If you are applying for disability benefit, our rules state that a disability benefit will be effective the month following receipt of the notice to retire or six months after the verified date of disability, whichever is later. Please be advised that in order to qualify for a disability benefit with the Fund you must include proof of approval for Social Security Disability Insurance from the U.S. Social Security Administration with your request. For more information about this benefit please refer to page 3.

Please indicate if you are married or single_____

If married please provide your spouse's date of birth_____

The enclosed Beneficiary Form must be completed and returned to us.

SHEET METAL WORKERS' NATIONAL PENSION FUND

DESIGNATION OF BENEFICIARY

PARTICIPANT: _____

LOCAL UNION: ____

SOCIAL SECURITY NUMBER: *****_____ (enter last four digits only)

Instructions: Give full name of the beneficiary, for example, Georgia M. Smith, not Mrs. Robert Smith. The Primary Beneficiary is the person or persons who will receive any benefit due in the event of your death. The Successor Beneficiary is the person or persons who will receive any benefit due in the event of the death of both you and the Primary Beneficiary. You may have as many Primary and Successor Beneficiaries as you wish. You may use an additional sheet of paper to list their names, addresses and relationships. Please be sure your signature is on the additional sheet. For further information see Article 7 and 8 of the Plan Booklet.

I hereby designate the following named beneficiary(ies) to receive the amount of benefit, if any, payable upon my death, under the Rules and Regulations of the National Pension Fund. I reserve the right to revoke and change this designation at any time by giving written notice to the Sheet Metal Workers National Pension Fund in the form designated by the Trustees.

Name of Primary Beneficiary_____Relationship_____

Address of Primary Beneficiary: _____
Street Address

_____
City State Zip

Name of Successor Beneficiary_____Relationship_____

Address of Successor Beneficiary: _____
Number & Street

_____
City State Zip

_____ _____
Signature of Participant Date of Signature

SHEET METAL WORKERS' NATIONAL PENSION FUND

FULL DISABILITY BENEFIT

For Full Disability Benefits, which become effective on or after January 1, 2008, both the eligibility requirements and the amount payable have changed.

In order to qualify for this benefit a Participant must meet the following conditions:

1) The U.S. Social Security Administration has found him to be disabled as verified by proof of approval for Social Security Disability Insurance;
2) He must have earned a minimum of 10 years of Pension Credit, which must include a minimum of 5 years of Future Service Credit;
3) He worked in Covered Employment for at least 435-hours in the 24-month period that immediately preceded the date that he was found to be disabled by the U.S. Social Security Administration;
4) He has not at any time performed any work in the Sheet Metal Industry that was not covered by a collective bargaining agreement between the Union and the employer. (It should be noted that the Plan provides an opportunity to restore eligibility); and
5) **The Participant has not attained age 55.**

The monthly amount of a Full Disability Benefit that becomes effective on or after January 2008 will be equal to the monthly amount of an early retirement pension that the Participant would have been eligible to receive if he were age 55 on the effective date.

To restate, a Full Disability Benefit requires that you submit a copy of your approval for Social Security Disability Insurance benefits, from the U.S. Social Security Administration. **The Award must be included with this application.**

Social Security Administration

Form Approved
OMB No. 0960-0602

Authorization to Obtain Earnings Data from the Social Security Administration

Mail completed form to:	Social Security Administration PO Box 33011 Baltimore, MD 21290-3011	Requesting organization:	SSA Job No 8279 Index 1 SHEET METAL WORKERS NATIONAL PENSION FUND 8403 BLVD, STE 300 FAIRFAX, VA 22031-4601

Number Holder's Information

First Name: Middle Initial:

Last Name:

SSN: -- --

Date of Birth: -- -- (Month Day Year)

Date of Death: -- -- (Month Day Year)

Other First, Middle Initial, and Last Name Used to Report Earnings:

Year(s) Requested: Y Y Y Y through Y Y Y Y

Y Y Y Y through Y Y Y Y

I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

Signature of Number Holder *(or authorized representative)*	Date -- -- (M M D D Y Y Y Y)
Printed Name *(if other than number holder)*	Relationship *(if other than number holder)* ☐ Spouse ☐ Legal Representative ☐ Other *(specify)*
Address / State	
City / ZIP Code	Phone Number

Requesting Organization's Information

SSA must receive this form within 60 days from the date signed by the Number Holder (or Authorized Representative)

Signature of Organization Official	Date
Phone Number	Fax Number

FOR SSA USE ONLY ☐1 ☐2 ☐3 ☐4

IMPORTANT INFORMATION

Privacy Act Statement
Collection and Use of Personal Information

Section 205(c)(2)(A) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to obtain earnings data. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed. We rarely use the information you supply us for any purpose other than to produce an itemized statement of earnings. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0059, entitled, Earnings Recording and Self-Employment Income System. Additional information about this and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*