Laborers' District Council

Benefit Funds

Reply to: 665 North Broad Street, 2nd FLOOR, PHILADELPHIA, PA 19123

Laborers' District Council
of the Metropolitan Area of
Philadelphia and Vicinity

For Pension and Health and Welfare Fund Services, please call:
Tel: ***1-877-LABOR-77*** *or* ***215-765-2014***
215-236-6700 *or* ***215-765-4633***
Fax: ***215-765-8329***

Dear Participant:

We are pleased to enclose the Annuity Application you requested. It takes on average sixty to ninety days to process an application for annuity benefits. When your eligibility has been determined we will notify you.

If you have any questions or need assistance in filling out the enclosed application, please feel free to contact our Pension Processing department.

Please remember that you MUST:

1. READ EACH QUESTION CAREFULLY
2. PRINT ALL INFORMATION
3. ANSWER ALL APPLICABLE QUESTIONS
4. ATTACH ADDITIONAL PAGES IF MORE SPACE IS NEEDED
5. SIGN THE APPLICATION
7. PLEASE INCLUDE A PHONE NUMBER WHERE YOU CAN BE REACHED.

MAIL COMPLETED APPLICATION AND ALL REQUIRED DOCUMENTS (i.e. marriage license; birth certificate; proof of age) TO THE ABOVE ADDRESS

FAILURE TO SIGN YOUR APPLICATION OR PROVIDE THE REQUIRED DOCUMENTS

- ✓ **WILL RESULT IN ADDITIONAL DELAYS IN THE PROCESSING OF YOUR CLAIM**
- ✓ **MAY RESULT IN YOUR BEING DETERMINED INELIGIBLE FOR BENEFITS.**

IMPORTANT

Participants and beneficiaries applying for benefits from the Laborers' District Council Construction Industry Pension Fund are now required to provide a copy of their social security card with their application for benefits. If married, the participant's spouse must also provide a copy of their social security card. This does not apply to the spouse's of beneficiaries.

Your claim will not be processed until we have copies of your social security card and if applicable your spouse's.

To get a replacement card, you will need to:

- **Complete an *Application For A Social Security Card* (Form SS-5);**
- **You can obtain Form SS-5 from our office, from your local Social Security office, online at www.socialsecurity.gov or by calling Social Security at 1-800-772-1213;**
- **MAIL OR TAKE THE COMPLETED FORM TO A LOCAL SOCIAL SECURITY OFFICE. Your local office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may also locate the nearest Social Security office on the Internet at http://www.socialsecurity.gov;**

Laborers' District Council Construction Industry Pension Fund
665 NORTH BROAD STREET, 2ND FLOOR
Philadelphia, Pa 19123
(215) 765-2014 • FAX (215) 765-8329

Annuity Distribution Application Form Web Application

To be completed by all Participants or (By the Beneficiary for death benefits)

1. Name of Participant	2. SSN of Participant

3. Address of Participant (Please include city state and zip)

4. Phone number *(please include area code)*	5. Participant's Date of Birth*(attach a copy of your birth certificate)*

6. Spouse's Name	7. Spouse's SSN	8. Spouse's Date of Birth

PARTICIPANT'S MARITAL STATUS? ***(PLEASE CHOOSE ONE)***

- ☐ MARRIED - *attach a copy of your marriage license, proof of your spouse's age and social security number)*
- ☐ DIVORCED - *attach a copy of your divorce decree **(must show seal or be certified**)*
- ☐ WIDOWED - *attach a copy of your spouse's death certificate*
- ☐ NEVER MARRIED
- ☐ MARRIED BUT CANNOT LOCATE MY SPOUSE

HAVE YOU RECEIVED ANNUITY BENEFITS OR ARE YOU ELIGIBLE TO RECEIVE ANNUITY BENEFITS FROM ANOTHER PENSION/ANNUITY FUND?

☐ YES ☐ NO

If YES, please give the name(s) of any Plan in which you have accumulated annuity benefits (If possible please include their address and phone number.)

_____
_____

Please indicate the last month you performed covered employment _____

Have you received Workers Compensation Benefits during the last two years? ☐ YES ☐ NO

(To be completed only by the (Beneficiary) for death benefits)

Name of Person applying for the deceased's Annuity	SSN

Address if different from deceased (Please include city state and zip)	Phone Number(please include area code)

Relationship to deceased ***(If spouse, please include copy of marriage license birth certificate and social security number)***	Deceased Date of Death ***(please include death certificate)***

I HEREBY APPLY FOR ANNUITY BENEFITS FROM THE LABORERS' DISTRICT COUNCIL CONSTRUCTION INDUSTRY PENSION FUND OF PHILADELPHIA AND VICINITY.

I agree to furnish any information that the Board of Trustees may require for the determination of my eligibility for Annuity Benefits at this time and at any other time in order to maintain my eligibility for Annuity Benefits.

_____ **[X]**_____
Signature of Witness **Signature of Applicant**

_____ _____
Address of Witness **Date Signed**

PROOF OF AGE

Every applicant is required to submit proof of age. For this purpose one or more of the following documents may serve as acceptable proof. Because some of these documents are better proof than others, the list is arranged so that the best type of proof is listed first, the next best is second and so on.

1. A birth certificate
2. A baptismal certificate, or a church record which shows the date of birth and is certified by the custodian of such records.
3. Notification of registration of birth in a public registry of vital statistics
4. Hospital birth record, certified by the custodian of such records
5. Birth record of a foreign church or government
6. A signed statement by the physician or midwife, who was in attendance at birth, showing the date of birth as it is taken from their records
7. Naturalization records
8. Immigration papers
9. Military record
10. Passport
11. School record, certified by the custodian of such records
12. Vaccination record, certified by the custodian of such record
13. An insurance policy (in force for at least 15 years) which shows ages or dates of birth
14. Marriage records showing date of birth or age (e.g. application for marriage license or church record) certified by the custodian of such records; or marriage certificate
15. Other evidence, such as signed statements from persons who have knowledge of the date of birth, voting records, poll tax receipts, etc.

WORKMEN'S COMPENSATION

Every applicant applying for pension credits as a result of receiving Workmen's Compensation must provide written proof that indicates the following:

1. The contractor you were working for when you sustained the injury
2. The date you started and stopped receiving Workmen's Compensation Benefits

If you do not have this information, the Fund office has forms that you can mail or take to one of the following sources:

1. The Insurance Company that paid your claim - (this is the best and quickest way to get the information)
2. The Workmen's Compensation Bureau, their address and phone number is

   Department of Labor and Industry
   Bureau of Workers Compensation
   1171 South Cameron Street, Room 103
   Harrisburg, Pa 17104-2501
   (Phone 800-482-2383 or 717-772-3742)

3. The contractor you worked for when you sustained the injury

WEEKLY DISABILITY BENEFITS

Every applicant applying for pensions credits as a result of receiving weekly disability benefits from a health and Welfare fund must submit written proof that indicates the following:

1. the name of the Health and Welfare Fund you received weekly disability benefits from
2. the date the you started and stopped receiving benefits

If you do not have this information, the Fund has forms that you can either take to or mail to the Health and Welfare to get the information or you may contact your Health and Welfare Fund directly.

LABORERS' DISTRICT COUNCIL HEAVY AND HIGHWAY AND/OR BUILDING AND CONSTRUCTION HEALTH AND WELFARE FUND
AUTHORIZATION FOR RELEASE OF INFORMATION

= Must be completed

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations. (Neither the plan nor Laborers' District Council receive financial or in-kind compensation in exchange for using or disclosing the health information described below.)

Participant name:_____ **SS Number:**_____

Date of Birth:_____

Persons/organizations providing the information:
Laborers' District Council Heavy and Highway Construction and/or Laborers' District Council Building and Construction Health and Welfare Fund

Persons/organizations receiving the information
Laborers' District Council Construction Industry Pension Fund

Specific description of information (including date(s)): ***Dependent and Beneficiary Census Information***

What is the purpose of the use or disclosure?: ***To help determine/verify the marital status of participant named above. The information will only be used to process a claim for pension and/or annuity.***

(**Note**: "at the request of the individual" is a sufficient description of the purpose of the use or disclosure when the participant initiates the authorization and elects not to provide a statement of the purpose.)

Section B: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the plan conditioning the provision of healthcare except that refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the plan declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. I understand that I get a copy of this form after I sign it. **I understand that this authorization will expire on the date I am no longer covered under the plan.** I understand that I may revoke this authorization at any time by notifying the plan administrator in writing. The revocation will only be effective from the date it is received and logged by the plan administrator and will not apply retroactively.

Participant initials: _____

_____ _____
Signature of participant or participant's representative **Date**
(Pertinent sections of the Form MUST be completed before signing.)

Printed name of participant's representative:_____

Relationship to the participant:_____
(PLEASE INCLUDE EVIDENCE OF AUTHORITY TO SIGN ON BEHALF OF THE PARTICIPANT)

= Must be completed