OHIO LABORERS Benefits

IMPORTANT PENSION APPLICATION INFORMATION

To complete the processing of your application, certain documents are necessary. Please provide the following documents with your application to help ensure it is processed in a timely manner.

- A copy of your **state-issued Birth Certificate**
- A copy of your **spouse's state-issued Birth Certificate** (if married)
- A copy of your **state-issued Marriage Certificate** (if married)
- A complete copy of your **Divorce Decree(s)** (if divorced). Include **Separation Agreement(s)**, if applicable.
- A copy of your **spouse's Death Certificate** (if widowed)
- A **Name Link** (if applicable). Please see the description of a Name Link at the bottom of page 1 of the application.

Additional Documentation may be required after Ohio Laborers Benefits reviews your application.

******BENEFITS COUNSELING IS AVAILABLE AND STRONGLY ENCOURAGED TO ASSIST YOU THROUGHOUT THIS PROCESS. IF YOU WOULD LIKE TO TAKE ADVANTAGE OF THIS SERVICE, PLEASE CALL OUR OFFICE AND SPEAK TO A BENEFITS COUNSELOR TO SCHEDULE AN APPOINTMENT AT YOUR LOCAL UNION HALL******

Under current IRS rules:

- You have the right to a 30-day period following the date you are provided with these Instructions to decide whether to apply for payment of your pension and to decide what form of payment to elect for the payment of your pension (as discussed below). You may waive this right by filing the Pension Application within this 30-day period.

- You must be provided with these Instructions no earlier than 180 days before the effective date for the payment of your pension. As a result, if you do not file the Pension Application early enough to establish an effective date for the payment of your pension (which can only be the first day of a calendar month) that is within 180 days of the date you are provided with these Instructions, you will have to obtain another copy of these Instructions before you file the Pension Application.

If you have any questions, feel free to contact the Pension Department at 800-236-6437 or via email at pension@ohiolaborers.com.

OHIO LABORERS Benefits

PENSION APPLICATION

Laborers' District Council and Contractors' Pension Fund of Ohio

800 Hillsdowne Road
Westerville, OH 43081-3302

Fax: (614) 413-2866
pension@ohiolaborers.com

Phone: (614) 898-9006
(800) 236-6437

To applicant: Please complete all questions and print your responses clearly. Be sure to sign and date page 5 of this application and submit the completed application along with all required documents to Ohio Laborers Benefits via mail, email, or fax, as listed above. If you have any questions regarding this form or how to complete it, please contact the Pension Department at one of the phone numbers listed above. Any Yes or No questions left unanswered will be considered as answered "No."

If you qualify for pension benefits from this Fund, you will receive "election forms" outlining all available benefit options after your application has been received and reviewed. To ensure timely processing, ***it is recommended that you submit your application 90 days before the date you would like your pension benefits to begin.***

PERSONAL DATA

Name: _____ SSN: _____
First Middle Last

Address: _____
Number and Street City and State Zip Code

Phone #: _____ / _____ Date of Birth: _____
Home Cell
Please submit a copy of your state-issued Birth Certificate.

Email Address: _____ Local Union #: _____

Marital Status *(please circle one)*: ***Married*** ***Single*** ***Divorced*** ***Widowed***

If **Married**, *please complete Step 1* ***and*** *Step 2 below.*

If **Single, Divorced or Widowed**, *please* ***only*** *complete Step 2 below.*

Step 1:

Spouse's Name: _____

Spouse's Date of Birth: _____ Date of Marriage: _____

Please submit a copy of your state issued Marriage Certificate and your spouse's state issued Birth Certificate

Step 2:

How many times have you been married (including current marriage if applicable): _____

Names of **ALL** previous spouses (if applicable): _____

_____

Please submit a complete copy of your Divorce Decree or Death Certificate for each previous marriage.

If your or your spouse's name on the Birth Certificate and Marriage Certificate do not match, you must also provide a Name Link. This generally occurs if the wife was married previously. A previous marriage certificate and/or child's birth certificate from a previous marriage may work as a Name Link if the maiden name is on the certificate. Or, you may complete a Name Affidavit, which you can request from Ohio Laborers Benefits.

EMPLOYMENT DATA & WORK HISTORY

- Last date you worked (or plan to work) as a laborer In this Fund's jurisdiction: _____

- Do you want to delay your Pension Effective Date? *(Please circle one)* ***Yes*** ***No***

If Yes, what month do you want your Pension Effective Date to be? _____

- Do you have pension hours in another Laborers' Pension Fund? *(Please circle one.)* ***Yes*** ***No***

If Yes, provide the requested information below for the other Fund(s) in which you have hours:

FUND NAME/STATE	LOCAL UNION #	PHONE NUMBER

- Have you served Active Duty with the U. S. Armed Forces? *(Please circle one.)* ***Yes*** ***No***

If Yes, indicate your dates of service and ***submit a copy of your DD214 form*** if you labored both before and after your active duty: _____

- Are you due Pension Disability Credit Hours? *(Please circle one.)* ***Yes*** ***No***

You may receive up to two pension credits or 2,000 Pension Disability Credit Hours (DCH) in your lifetime. DCH will not be granted for any year in which you have already earned a pension credit and will only be granted up to 1,000 hours in a calendar year (DCH and work hours combined).

If Yes, indicate the dates of your disability: _____

Additionally, for work related disabilities, ***please submit a letter or computer printout from the Ohio BWC*** stating the type of benefits you received, the period of time you received such benefits (including date of injury), and the name of company on which the claim was filed. To be entitled to disability credit hours, your claim must be from laboring work with a signatory employer.

Additionally, for non-work related disabilities, ***please submit a Short Term Disability Form*** from the OLDC-OCA Insurance Fund. *(Call Ohio Laborers Benefits or download the form at www.ohiolaborers.com.)*

BENEFIT INFORMATION

Please check which type of Pension Benefit you wish to apply for at this time. Refer to your Summary Plan Description or contact Ohio Laborers Benefits for the minimum requirements for each Pension Type:

( ) Regular Retirement Benefit

( ) Early Retirement Benefit

( ) Special Service Retirement Benefit

( ) Disability Pension Benefit

Social Security Leveling Options

Please refer to your Summary Plan Description or contact Ohio Laborers Benefits for an explanation of how Social Security Leveling works. (Social Security Leveling is not available with Disability Pensions or for those with an Earliest Retirement age of 58 years old.)

Would you like to receive Social Security Leveling Options with your election forms? *(Please circle one)* ***Yes*** ***No***

If Yes, ***please submit documentation from the Social Security Administration stating the estimated amount of your Social Security benefit at your Social Security Normal Retirement Age.*** *By selecting yes, you are not electing a Social Security Leveling option. You will have the opportunity to make a final election regarding this option when you complete your election forms.*

COMPLETE THE FOLLOWING ONLY IF YOU ARE APPLYING FOR A DISABILITY BENEFIT

Date you first became Disabled from Laboring: _____

What is your Disabling Condition? _____

Have you been approved for Disability Benefits from Social Security? *(Please circle one.)* ***Yes*** ***No***

If you have been approved for Disability Benefits from Social Security, ***please submit a copy of your award letter from Social Security.***

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR A DISABILITY BENEFIT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO THE LABORERS' DISTRICT COUNCIL AND CONTRACTORS' PENSION FUND OF OHIO

Information about the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. ***I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to my healthcare provider(s).***

Applicant's Name: _____ **Social Security Number:** _____

Persons/organizations authorized to provide the information: **Any of my healthcare provider(s), including:**

Full Name of Doctor: _____

Doctor's Address: _____

_____

_____

Doctor's Telephone: _____ **Fax:** _____

Persons/organizations authorized to receive the information: **Laborers' District Council and Contractors' Pension Fund of Ohio ("Fund")**

Specific description of information to be used or disclosed (including date(s)): **I authorize my healthcare provider(s) to disclose protected health information received by and created by my healthcare provider(s) relating to any condition, illness, or injury for which I am asserting has rendered me eligible for a disability pension benefit, and any other information required by the Fund in connection with my application for a pension benefit.**

Specific purpose of the disclosure: **At the request of the Individual.**

This authorization will expire **within 360 days from the date it is executed.**

Important Information about Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying my health care provider(s) in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation. My right to revoke an authorization is set forth in my health care provider(s)' Privacy Notice.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment), except in very limited circumstances.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and no longer protected by the privacy regulations.

_____ _____

Signature of Applicant or Applicant's Representative **Date**

If signed by a personal representative, please print the name of the personal representative and the personal representative's relationship to the Applicant, including authority for status as representative:

_____

Notice: The use of this Authorization to request medical information on behalf of the applicant for a pension benefit does not obligate the Fund to accept or honor any charge for the provision of medical information to the Fund. Any fees charged for medical information are the sole responsibility of the applicant.

CERTIFICATION

Please read this section carefully and sign at the bottom of the page.

RULES ON EMPLOYMENT AFTER RETIREMENT

I understand that the Internal Revenue Code requires I have a bona fide separation of employment by completely terminating all employment with any Employer in the industry in order to be eligible for my pension benefit from the Laborers' District Council and Contractors' Pension Fund of Ohio. I also understand Pension Plan rules dictate that I subsequently can't return to employment until at least 30 days after my retirement date. If I do return to employment at that time, I am aware of the types of employment that are considered "disqualifying employment" and would cause my monthly pension benefits to be suspended. I understand that different rules apply depending on my age and work history. I understand I can read the complete rules on disqualifying employment in the Fund's Summary Plan Description and at www.ohiolaborers.com. I understand that if I receive my Pension Benefits for a month in which it should be suspended, I will be responsible for reimbursing the Pension Fund all monies due. If I have any questions about these rules, I know to contact the Pension Department at Ohio Laborers Benefits. *(The following rules only apply to Pension Benefits from the LDC&C Pension Fund of Ohio and Insurance Benefits from the Ohio Laborers' District Council - Ohio Contractors' Association Insurance Fund.)*

Retiree Insurance

If my monthly pension benefit is suspended due to Disqualifying Employment and I have elected Retiree Insurance from the OLDC-OCA Insurance Fund, I could lose the Retiree Insurance Subsidy for the rest of my life. If I lose the subsidy, my Retiree Insurance premium from the Insurance Fund could be significantly higher. *(Please refer to information received from the Insurance Fund for further details.)*

Notifying Ohio Laborers Benefits

If I begin to work in Disqualifying Employment, I must provide written notice to Ohio Laborers Benefits within 30 days of starting such employment. If I am not sure if a particular job is considered Disqualifying Employment, I will contact Ohio Laborers Benefits for a determination. I may need to provide a job description from my employer for this determination. Ohio Laborers Benefits may request reasonable information from me and/or my employer at any time to verify my employment and the number of hours I am working.

By executing this Certification, I hereby apply for a pension benefit from the Laborers' District Council and Contractors' Pension Fund of Ohio. I certify the enclosed statements are true and accurate to the best of my knowledge and belief. I further certify that I have read, understand, and agree to comply with the Rules on Employment After Retirement, and acknowledge there are additional rules and provisions in the Plan Document and Summary Plan Description that may impact my pension benefit.

I hereby authorize the Trustees of the Laborers' District Council and Contractors' Pension Fund of Ohio to examine my Social Security records and/or any other pertinent documents in regard to my earnings or employment during any calendar year following the effective date of my pension benefits. If applying for a Disability Pension Benefit, I hereby authorize the Laborers' District Council and Contractors' Pension Fund of Ohio to forward my medical records to a third-party review organization.

I hereby authorize any other pension fund signatory to the LIUNA National Reciprocal Agreement to release any and all information regarding my pension benefits to the Laborers' District Council and Contractors' Pension Fund of Ohio. I understand that a false statement may disqualify me for pension benefits, and that the Trustees shall have the right to recover any payment made to me because of a false statement.

Applicant's Signature _____ **Date** _____