NECA-IBEW LOCAL NO. 176 PENSION TRUST FUND

Required:

Please include a copy of ID or Birth Certificate

NECA – IBEW LOCAL NO. 176
Pension Trust Fund

ELECTION OF RETIREMENT DATE

TO: Trustees of
NECA – IBEW Local No. 176
Pension Trust Fund

FROM: _____
(please print)
_____
_____

I understand that the date I choose to terminate or retire can effect the way my benefits are calculated. Please calculate my benefits as follows (check one):

☐ As soon as possible after my first request; I understand I will not earn interest credits for the current Plan Year.

☐ Effective as of June 1, 20_____, or December 1, 20_____, I understand that actual payment of benefits cannot be made until the Auditor selected by the Trustees determines the appropriate interest credit for the current Plan Year or six (6) month period.

I understand that, by giving me this form, the Trustees do not admit that I am eligible for any benefit or any specific benefit amount from this Plan.

Date: _____ Signature: _____

NECA – IBEW Local No. 176 Pension Fund

APPLICATION FOR PENSION BENEFITS

(Please read carefully and complete fully)

RE: _____ SSN: _____
(PARTICIPANT NAME)

TO: The Board of Trustees
I hereby apply for the following Pension Benefits:

_____ Retirement Benefits for Participants age 55 or Over (Attach copy of Birth Certificate)

_____ Disability Benefits (Attach copy of Social Security Disability Award Certificate)

_____ Pre-Retirement Death Benefits (Attach CERTIFIED Death Certificate)

_____ Termination Benefit

When applying for one of the above benefits, one of the following options must be elected. (See explanation of the options on reverse side of this form. Additional information can be obtained from the Administration Office.)

_____ **Single** lump-sum payment.

_____ **Partial** lump-sum payment (5% increments of payments can only be requested June 1 or December 1 of each year.) **Spousal consent is required each time a partial payment is made.**

_____ Joint and 50% Survivor Annuity*.

****

PARTICIPANT INFORMATION: (Please Print)

1. Name in full _____ 2. SS# _____

3. Mailing Address: a) Street _____

   b) City _____ c) State _____ d) Zip _____

4. Date of Birth _____ 5. Last Employer _____

6. Local Union No. _____ 7. Date of Retirement Requested _____

8. Last Date Worked _____ Phone _____

9. Marital Status _____

****

* **Joint and 50% Survivor Annuity** – An Annuity purchased by the Fund on your behalf in which the Employee's spouse is named as the contingent annuitant and which will be paid for the remaining full joint lifetime of the employee and his spouse.

Continued on back...

SPOUSE INFORMATION: (Please Print)

Spouse's Name _____

Spouse's Mailing Address _____

City _____ State _____ Zip _____

Spouse's Social Security # _____ Spouse's Date of Birth _____

Date of Marriage _____

In the event you are applying for Normal or Disability Retirement and will have been married for a period of at least one full year at the time benefits commence, the written consent of your spouse will be required on Form 1 in order for you to be able to elect any benefit payment option other than a Joint and 50% Survivor Annuity. Your spouse's signature must be witnessed by a Notary Public.

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BENEFICIARY INFORMATION: (Please print or type)

In the event you are applying for a Death Benefit, please complete the following section:

Beneficiary Name _____

Mailing Address _____

_____

Beneficiary SSN: _____ Phone _____

Relationship to Participant _____

Beneficiary Signature _____

****

Before final action can be taken on this application, validation by a Notary Public **must** be secured.

Signature of Employee _____ Date _____

Signature of Beneficiary _____ Date _____

Date _____ County of _____

Subscribed and sworn before me this _____ day of _____, 20_____

Notary Public _____

My Commission Expires _____

N.E.C.A. – I.B.E.W. LOCAL NO. 176
DEFINED CONTRIBUTION PENSION PLAN

ROLLOVER ELECTION FORM

TODAY'S DATE: _____

PROVIDED TO:

_____ _____
Participant/Spouse/Beneficiary Name Here Social Security Number

_____
Street Address/Apt. Number (if applicable)

_____
City State Zip Code

ATTENTION: BEFORE COMPLETING THIS FORM YOU SHOULD READ CAREFULLY THE SPECIAL TAX NOTICE REGARDING PAYMENT FROM THIS PLAN. YOU MAY ALSO WISH TO CONSULT YOUR TAX ADVISOR BEFORE MAKING THIS ELECTION.

THIS FORM MUST BE COMPLETED ONLY IF YOU WILL RECEIVE A PAYOUT IN A LUMP SUM, OR OTHER ELIGIBLE ROLLOVER DISTRIBUTION.

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 to another retirement plan, this Plan is required to withhold 20 percent of the payment for federal income taxes. This withholding does not increase your taxes; it will be credited against any income tax you owe. For further information on direct rollovers and withholding, please read the Special Notice Regarding Plan Payments that this Plan has given you.

PART A: WAIVER OF ROLLOVER

I do not want to roll over any of my payment from the Plan to an IRA or to another qualified retirement plan. Please pay me the full amount of my benefit, after withholding 20 percent for federal income taxes as required by law.

_____ _____
Participant/Spouse/Beneficiary Signature Date

PART B: ELECTION FOR ROLLOVER IN WHOLE OR IN PART

Check below to indicate your choice of rollover payment:

_____ I want to roll over my payment directly to an IRA or to another qualified retirement plan that accepts rollovers. The IRA or other qualified retirement plan is named below.

_____ I wold like to have only part of my payment directly rolled over. Please roll over $ _____ to the IRA or other qualified retirement plan named below. Pay the remainder of my benefit to me, after withholding 20 percent for federal income taxes as required by law.

You must provide all of the following information and sign where indicated to complete a direct rollover. Until you provide this information, your application will be considered incomplete and no payment will be made either to you or to the rollover plan.

_____ _____

Name of IRA Trustee/Qualified Retirement Plan Account Number

_____

Street Address

_____

City State Zip Code

CERTIFICATION

Please read the following statement carefully and sign where indicated:

I certify that the recipient of a direct rollover that I have named above is an Individual Retirement Account, and Individuals Retirement Annuity or a qualified retirement plan that accepts rollovers. I understand that payment of my benefit to the trustee of the name IRA or qualified retirement plan will release the Trustees of the N.E.C.A. – I.B.E.W. LOCAL NO. 176 DEFINED CONTRIBUTION PENSION PLAN from any further obligations or responsibilities with respect to the benefit so paid.

_____ _____

Signature Date

NECA – IBEW LOCAL NO. 176 PENSION FUND

SPOUSE'S CONSENT TO WAIVER OF

JOINT AND 50% SURVIVOR ANNUITY

I, _____, as spouse of _____, hereby acknowledge that the Joint and 50% Survivor Annuity benefits have been explained to me and that I consent to my spouse's election to waive the Joint and 50% Survivor Annuity.

Date _____ Signature of Spouse _____

Date _____ County of _____

Subscribed and sworn before me this _____ day of _____, 20_____

Notary Public _____

My Commission Expires _____

NECA – IBEW LOCAL NO. 176
Pension Trust Fund

Incremental Benefit Payout

Eligible Participants will be allowed two (2) pension distributions annually, June 1st or December 1st of each Plan Year. The distribution will only be allowed as long as it is devisable by 5% of the total Pension Benefit (for example, 10%, 20%, etc.) and shall include interest for the period in which the distribution is made. The Fund will have a preliminary audit by its CPA to ascertain the interest to be allocated on the allocation date of December.

Additionally, if a Participant chooses to have an allocation in December and then an allocation in June, the interest payable in June will not exceed the total interest allocated to all Plan Participants for the full Plan Year (June 1 through May 1). Each time a Participant requests a benefit allocation, spousal consent is required.

If you have any questions regarding this, please contact the Administration Office.

INCREMENTAL BENEFIT PAYOUT ELECTION

Name in full _____ Social Security # _____

Address _____ City _____

State _____ Zip Code _____

As described previously, please advise the Pension Benefit amount you wish paid. It must be in 5% increments.

Effective as of June 1, 20_____, _____% payout.

Effective as of December 1, 20_____, _____% payout.

NOTE: **ONLY TWO (2) INCREMENTAL PENSION BENEFIT PAYOUTS ARE ALLOWED DURING A PLAN YEAR; JUNE 1ST THROUGH MAY 31ST.**

Date _____ Signature _____