NORTHWEST GLASS, MOLDERS, POTTERY, PLASTICS AND ALLIED WORKERS PENSION TRUST

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 664-7300 or (800) 426-7132 • Fax (206) 695-0984 • Website: https://www.nwgmp-pension.com
Administered by
Welfare & Pension Administration Service, Inc.

APPLICATION FOR RETIREMENT BENEFITS

[NOTE: Application must be at the Administration Office at least 60 days prior to the effective date requested below.]

[Please print in ink or type.]

NAME: _____ SOCIAL SECURITY NO.: _____
Last First Middle Initial
LIST OTHER LAST NAME(S)/MAIDEN NAME(S) USED: _____ DATE OF BIRTH: _____

MAILING ADDRESS: _____
Street and Number City State Zip Code
HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ EMAIL ADDRESS: _____

CONTACT PERSON OTHER THAN SPOUSE: _____ (_____) _____
Name Phone
UNION LOCAL NO.: _____ MOST RECENT EMPLOYER (whether or not in Plan):_____
Name of Company City
DATE LAST WORKED **OR** DATE YOU INTEND TO TERMINATE PRESENT EMPLOYMENT: _____

RETIREMENT BENEFITS TO BE EFFECTIVE - 1ST DAY OF: _____/_____
Month **Year**
(Please note that the earliest effective date you can elect is 60 days after the first of the month following our receipt of this application.)

MARITAL STATUS: SINGLE ☐ *DIVORCED ☐ *WIDOWED ☐ *REMARRIED ☐ MARRIED ☐
***If widowed, you must submit a copy of the spouse death certificate. If divorced/remarried, you must submit a complete copy of your final divorce decree(s) and any related "qualified domestic relations order" (QDRO).**

NAME OF SPOUSE: _____ SPOUSE SOCIAL SECURITY NO.: _____
First Middle Initial Last, if different
SPOUSE DATE OF BIRTH: _____ DATE MARRIED: _____

IF YOU ARE APPLYING FOR DISABILITY RETIREMENT BENEFITS PRIOR TO AGE 65, CHECK THIS BOX: ☐

NOTE: If you are not applying for disability benefits and you are married, you will be furnished with an election of benefit form showing your various benefit options between 30-90 days prior to your retirement effective date. Your completed, notarized election of benefit form must be received prior to your effective date. If you are not married, benefits will be paid to you for your lifetime only (Plan Section 507.) If you are applying for disability benefits, the benefit will be paid to you so long as you meet the requirements for disability (Plan Section 506.)

This application may be canceled, in writing, at any time prior to the disbursement of the initial benefit payment.

I understand that my eligibility to receive the benefit requested herein is governed entirely by the provisions of the retirement plan or as the same may hereafter be amended, and that the payment to me of any amount in excess of that to which I am entitled will be recovered by the plan.

NOTARIZATION
Subscribed and sworn to before me_____
this ____ day of _____, 20 _____
Notary Signature _____
Notary Public in and for the State of _____
Residing at _____
My commission expires _____

[Notarization required for unmarried or disability applicants only.]

_____
PARTICIPANT SIGNATURE

DATE: _____

[Unmarried and disability applicants, please see Page 3.]

EMPLOYMENT HISTORY

List all employers you worked for in the Foundry and/or Patternmakers trades since 1950 and indicate all local unions regardless of whether you believe they were covered under this plan. Please furnish at least approximate dates of employment with each employer. Your employment history will be verified from all available sources; however, the final burden of submitting proof shall rest with you.

List present employer first. Then list all employers in reverse order back to the first employer you had in this industry. Report any periods of six or more months in which you were unemployed and state the reason. Also include any periods you worked for an employer under this Plan in a non-bargaining unit capacity. If more space is needed, use additional sheets of paper and attach them to this application.

The employment history is an important part of your retirement application. It assists the administration office in determining whether all applicable forms of service have been reported on your behalf.

NAME OF EMPLOYER / CITY	POSITION OR JOB TITLE	LOCAL UNION NUMBER (if any)	FROM (Month / Year)	TO (Month / Year)
PRESENT EMPLOYER 1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

A Break-In-Service due to service in the Armed Forces of the United States may be canceled if a participant submits as proof a photocopy of their DD-214 Military Discharge form. Enter below all dates of any United States military service.

Branch of Service:	From (Month / Year):	To (Month / Year):

INSTRUCTIONS FOR FURNISHING PROOF OF AGE

At the time you submit this completed application to the pension office, or as soon as possible thereafter, you must furnish proof of age.

Submit either one document listed under Group I or two documents listed under Group II. Photostatic copies are acceptable except for passports, naturalization papers or immigration papers which may not be photocopied by federal law. If you submit any original documents, they will be returned to you.

Additional proof of age may be requested if the documents you submit do not provide conclusive proof of your date of birth.

Group I (one required)

1. Birth Certificate
2. Infant Baptismal Certificate
3. Any governmental agency record of birth certified by the custodian of such record
4. Hospital Birth Record
5. Naturalization Record (submit original)
6. Immigration papers (submit original)

OR

Group II (two required)

7. Military Records
8. Passport at least 10 years old (submit original)
9. School records, certified by custodian of such record
10. Insurance policy which shows age or date of birth (at least 10 years old)
11. Marriage records showing age or date of birth
12. Notarized affidavits by persons who have knowledge of your date of birth

Note: If you are married and elect a spouse option form of benefit you must submit proof of age of your spouse as described above at the time you make an election. A copy of your marriage certificate will also be required if you elect a spouse option form of payment.

BENEFICIARY DESIGNATION FOR UNMARRIED PARTICIPANT

Section 507(a) provides that if you should die before receiving sixty (60) monthly payments, benefit payments will continue to your designated beneficiary until the earliest of (1) the designated beneficiary's death or (2) any combination of sixty (60) monthly payments to you and your beneficiary. Please designate your beneficiary below. You may list more than one beneficiary. However, you may not designate an institution or your estate as your beneficiary. You, as the participant must sign below. Do not have the beneficiary sign.

NAME: _____ ADDRESS: _____
Last First Middle Initial Street and Number City State Zip Code

SSN OF BENEFICIARY:_____ DATE OF BIRTH: _____ PHONE ._____

RELATIONSHIP:_____ **PARTICIPANT'S SIGNATURE**:_____ DATE: _____

DISABILITY RETIREMENT

If you are applying for disability retirement benefits, you must complete the authorization to release medical information on the back of this form. If your application is approved, your monthly benefit will be your Normal (age 65) Retirement benefit with no reduction for age. A spouse option form of payment will be available to you when you attain age 65. In the event of your death before age 65, your spouse will be eligible for a preretirement death benefit.

Have you applied for Social Security Disability? Yes__ No__ If you have an approval letter, please provide a copy.

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7525 SE 24th St., Suite 200, Seattle, WA 98124 (206) 664-7300

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO THE NORTHWEST GMP PENSION TRUST

Complete this form only if you are applying for **Disability Retirement** benefits.

MEDICAL SOURCE (PHYSICIAN'S NAME, ADDRESS AND TELEPHONE NO.)

_____

_____

_____

APPLICANT'S NAME AND ADDRESS _____

_____

_____

APPLICANT'S TELEPHONE NO. _____

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

PERIOD OF TREATMENT:_____ **FROM** _____ **TO**

AUTHORIZATION

I hereby authorize the above named medical source to disclose medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition (including psychological or psychiatric impairments) during the period(s) identified above to the Northwest GMP Pension Trust. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for disability benefits under the Retirement Plan of the Northwest GMP Pension Trust.

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 the organization providing the information.

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

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurance from the above-named person/organization authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

I UNDERSTAND THAT IF THE MEDICAL SOURCE CHARGES A FEE FOR ITS REPORT, I AM RESPONSIBLE FOR PAYING THE FEE.

_____ _____

Signature of Applicant (or person acting on his/her behalf) Relationship to Applicant

Date_____