

**Building Trades United Pension Trust Fund
Milwaukee & Vicinity**

**500 Elm Grove Road, Room 300
PO Box 530
Elm Grove, WI 53122**

**Phone: (262) 784-7880
Toll Free: (800) 433-8570**

APPLICATION FOR DISABILITY BENEFITS

Introductory Note

This authorized application form is used when applying for benefits payable under the Pension Plan. All the information and signatures asked for must be furnished by you and, if you are married, by your spouse. Copies of certain records are also required in support of this application. You will receive an explanation of the records needed for your application; the amount of benefits to which you, your spouse and beneficiaries may be entitled; and a Benefit Illustration Sheet to help you understand your options.

Application to the Eligibility Committee of the Board of Trustees

A. Information About Myself (Participant)

Name in Full _____

Social Security # _____

Mailing Address _____

City State Zip

Phone (_____) _____

Birthdate _____

Trade _____

Local Union No. (if any) _____

B. Information About My Spouse

Are you currently legally married? ☐ Yes ☐ No

If Yes:
Name of Spouse _____

Spouse's Address _____
(if different than Participant's)

City State Zip

Maiden Name (if female spouse) _____

Social Security # _____

Birthdate _____

C. Information About Past Marriages

Have you had any past marriages? ☐ Yes ☐ No

If Yes, list the names of all former spouses along with the dates your prior marriage(s) began and ended.

(1) Former Spouse's name _____

Dates of this marriage (from what year to what year?) _____

How did this marriage end? ☐ Divorce* ☐ Spouse died**

(2) Former Spouse's name _____

Dates of this marriage (from what year to what year?) _____

How did this marriage end? ☐ Divorce* ☐ Spouse died**

(3) Former Spouse's name _____

Dates of this marriage (from what year to what year?) _____

How did this marriage end? ☐ Divorce* ☐ Spouse died**

If you have been married more than 3 times before, please attach a separate piece of paper providing the above-requested information.

If you have ever been divorced, was any portion of your retirement benefits from the Building Trades United Pension Trust Fund assigned to a former spouse as part of a marital settlement agreement or Qualified Domestic Relations Order? ☐ Yes ☐ No

If Yes, please explain:

*Note: If you have ever been divorced, you will need to send copies of your divorce decree(s) and marital settlement agreement(s) along with this application if you have not provided them to our office in the past.

**Note: If you have ever been widowed, you will need to send us a copy of your spouse's death certificate if you have not provided it to our office in the past.

D. Type of Benefit (Select one, or two if Pro Rata)

- ☐ 24-Month Disability Benefit
- ☐ Total and Permanent Disability Benefit
- ☐ Pro Rata Benefit

Note: Proof of a Social Security award of disability benefits or a medical report(s) from your doctor(s) on your condition is required to complete your application for disability benefits.

Effective Date _____

Annuity Starting Date _____
(Annuity Starting Date cannot be prior to the first of the month following receipt of the completed application in the Fund Office.)

E. Election of Benefit Option (Select One)

- ☐ Lifetime Only
- ☐ Automatic Joint and Survivor
- ☐ Pop-up Joint and Survivor
- ☐ 75% Joint and Survivor
- ☐ Non-spouse Survivor (Complete Section F also)

Note: Depending on your age, marital status, and the type of Disability Benefit for which you are applying, certain benefit options listed above might not be available to you. Your benefit illustration explains the options that are available.

If you are married and choose an option other than the Automatic Joint and Survivor option, you and your spouse must sign the waiver form provided by the Pension Fund Office. The signatures on the waiver must be notarized or may be witnessed by a Fund representative when your spouse's identity is verified.

You may not change your option selection after your Annuity Starting Date. If you are married and do wish to change your option selection *prior* to your Annuity Starting Date, you and your spouse may be required to sign a new waiver form provided by the Pension Fund Office.

F. Designation of Beneficiary(ies) for Non-spouse Survivor Option

You should not complete this section *unless* you chose the Non-spouse Survivor option in Section E.

Note: If you list more than one beneficiary, each person listed will receive an equal share of any benefits payable. If you wish to list more than two beneficiaries, please list all beneficiaries on another piece of paper and attach it to this application.

Following is/are my beneficiary(ies) for Non-spouse Survivor Benefits:

(1) Name _____

Date of birth _____

SS# _____

Relationship to you _____

Address _____

(2) Name _____

Date of birth _____

SS# _____

Relationship to you _____

Address _____

G. Work Related Information

1. Have you had ownership interest in a company that made contributions to this Fund under a Collective Bargaining Agreement?

☐ Yes ☐ No

Company Name _____

Approximate Dates _____

If your answer is yes, was the company incorporated?

☐ Yes ☐ No

2. Have you worked under the jurisdiction or labor contract of any other local in the construction industry since June 1, 1959?

☐ Yes ☐ No

If your answer is yes, complete the following:

Local #	Location	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Over Please)

G. Work Related Information *(Continued)*

3. If your answer to #2 is yes, please read the enclosed Pro Rata Benefit information sheet. After reading it, are you interested in pursuing a Pro Rata Disability Benefit?

☐ Yes ☐ No

4. Are you currently working in the construction industry?

☐ Yes ☐ No

5. If your answer to #4 is yes, complete below. If no, skip to #6.

Employer _____

Date you plan to stop working in construction related employment: _____

6. If your answer to #4 is no, list the date you were forced to stop working in construction due to your disability:

Month

Year

7. Are you currently employed *outside of* the construction industry?

☐ Yes ☐ No

8. If your answer to #7 is yes, what was your total income for work performed outside of the construction industry since the time you were forced to stop working in construction related employment?

9. Do you plan on returning to work at your trade?

☐ Yes ☐ No

If the answer is yes, please explain:

10. The name of your most recent contributing Employer is:

H. Important Information about Disability Benefits

If you are applying for the **24-Month Disability Benefit**, you will need to provide new medical information every eight months. This benefit is not paid for longer than 24 months under any circumstances. Disability benefits may be discontinued for various reasons. If you do not receive disability benefits for the full 24 months, benefits must be repaid.

If you are applying for **Total and Permanent Disability Benefits**, you will need to provide proof each year that you continue to be totally and permanently disabled. Disability Benefits may be discontinued for various reasons.

Please refer to your Summary Plan Description for more detailed information about disability benefits.

I. Certification

I hereby certify that all of the information furnished by me, including any attachments or additions to this form, as well as any records or documents supplied in support of this application are, to the best of my knowledge and belief, true, complete and correct. I understand any fraudulent information could cause this application to be invalid.

I understand I must submit proof of my age and if applicable, proof of my spouse's age or non-spouse survivor's age acceptable to the Trustees. I understand that if I am married, and over age 55 or applying for Total and Permanent Disability Benefits, I must submit a copy of my Marriage Certificate.

I certify I have notified the Pension Fund of any judgment, decree or order, i.e. as a result of a divorce or child support, either current or pending, which might recognize the

existence of an alternate payee's right to receive all or a portion of the benefits payable to me under the Plan. I further agree to indemnify the Plan for any payments the Plan may make, relating to such judgment, decree or order, either current or pending, or rendered in the future, where such payments exceed the benefits to which I am otherwise entitled.

Date _____

Signature _____

Please Print Name _____

In the presence of _____
(this line is for office use only)