OLFBP
Ohio Laborers' Fringe Benefit Programs

PENSION APPLICATION

Laborers' District Council and Contractors' Pension Fund of Ohio

800 Hillsdowne Road
Westerville, OH 43081-3302
www.olfbp.com

Phone: (614) 898-9006
(800) 236-6437
Fax: (614) 898-9169

To applicant: Please complete all questions and print your answers. You and a witness must sign and date page 6 of this application. Please submit with your application all requested documents to the OLFBP Fund Office. If you have any questions regarding this form or how to complete it, please contact the Pension Department at one of the above telephone numbers. If you fail to answer a Yes or No question in this application, your answer will be deemed to be "No." ***If you would like to meet with an OLFBP Fund Office representative to assist you with the completion of this application or other retirement paperwork or to provide you with an explanation of benefit options, please contact a Benefits Counselor at one of the above telephone numbers.***

If you qualify for pension benefits from this Fund, you will receive "election forms" which indicate all the benefit options available to you upon receipt of the completed application. ***The Fund Office recommends that you apply for pension benefits 90 days before you wish for your benefits to commence.***

PERSONAL DATA

Name:_____ SSN:_____
(First) (Middle) (Last)

Address:_____
(Number and Street) (City and State) (Zip Code)

Telephone Number:_____ Date of Birth:_____
Please submit a copy of your state issued Birth Certificate.

Email Address:_____ Local Union Number:_____

Marital Status *(please circle one)*: ***Married*** ***Never Married*** ***Divorced*** ***Widowed***

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

If currently married, *please complete the following and* ***submit a copy of your state issued Marriage Certificate and your spouse's state issued Birth Certificate:***

Spouse's Name:_____

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

Names of all previous spouses (if applicable):_____
Please submit a complete copy of your Divorce Decree (including Separation Agreement if applicable) 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 or child's birth certificate from a previous marriage may all work as a Name Link if the maiden name is on the form. Or, you may complete a Name Affidavit, which you can request from the Fund Office.

EMPLOYMENT DATA & WORK HISTORY

Earliest Union Initiation Date or
Year First Employed in the Construction Industry in this Fund's Jurisdiction:_____

Last Date You Worked (or Plan to Work) as a Laborer:_____

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 plan to work in the Construction Industry after receiving your pension benefits from this Fund *(please circle one)*? ***Yes*** ***No***

If Yes, name of company for which you plan to work:_____

If Yes, what will your job title be?_____

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

If Yes, list the Fund(s) or the State(s) and Local Union(s) in which you have hours:_____

_____

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 the OLFBP Fund Office or download the form at www.olfbp.com.)*

BENEFIT INFORMATION

Please check which type of Pension Benefit you wish to apply for at this time:

( ) Regular Retirement Benefit

( ) Early Retirement Benefit

( ) Special Service Retirement Benefit

( ) Disability Pension Benefit

Please refer to your Summary Plan Description or contact the OLFBP Fund Office for the minimum requirements for each Pension Type.

Social Security Leveling Options

Would you like to receive Social Security Income Leveling Options with your election forms?
(Social Security Leveling is not available with Disability Pensions.) Please circle one: ***Yes*** ***No***

If Yes, ***please submit a letter from the Social Security Administration stating the estimated amount of your Social Security benefit at normal retirement age.*** *This estimate must include your first and last names, date of birth or last four digits of your Social Security number, and your estimated benefit at 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.*

Please refer to your Summary Plan Description or contact the OLFBP Fund for an explanation of how Social Security Income Leveling works.

Disability Pension Benefits

If Applying for Disability Pension Benefits, *please complete the following:*

Date you first became Disabled from Laboring:_____

What is your Disabling Condition?_____

Have you applied or do you intend to apply for Disability Benefits from Social Security *(please circle one)*? ***Yes*** ***No***

If Yes, on what approximate date did you apply or intend to apply?_____

If Yes, have you received a decision *(please circle one)*? ***Yes*** ***No***

If Yes, was your claim approved or rejected *(please circle one)*? ***Approved*** ***Rejected***

If Approved for Disability Benefits from Social Security, ***please submit a copy of your award letter from Social Security.***

If you are applying for Disability Pension Benefits, *please complete this form.*

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 redisclosed 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 make sure you sign, date, and have witnessed on page 6.

RULES ON EMPLOYMENT AFTER RETIREMENT

As a retiree of the Laborers' District Council and Contractors' Pension Fund of Ohio, I am aware of the types of employment which would cause my monthly pension benefits to be suspended. I understand that different rules apply depending on my age and work history. I understand that if I receive my Pension Benefit 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 the OLFBP Fund Office. *(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.)*

Disqualifying Employment

Disqualifying employment generally includes working for an employer in covered employment or employment for which contributions are required to one or more of the following funds: LDC&C Pension Fund of Ohio, OLDC-OCA Insurance Fund, Ohio Laborers' Training and Apprenticeship Trust Fund, or OLDC-OCA Cooperation and Education Trust Fund (LECET). Laboring in Local 310's or Local 265's jurisdiction *(and with other smaller laboring pension funds within Ohio)* is considered Disqualifying Employment, even if contributions are not due to this Pension Fund. Performing the same work that you have done in the past if contributions were made to one or more of the above funds for such work is also considered Disqualifying Employment.

Disqualifying Employment includes working as a Laborer Foreman. It does not include working as a superintendent <u>if</u> acting as a "supervisor" within the meaning of the National Labor Relations Act. Generally, this means having the discretion to do one of these functions: hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsible to direct them, adjust their grievances, or effectively recommend these actions. If I supervise Laborers, but do not meet the above description of a "supervisor," the work will be considered Disqualifying Employment, regardless of job title. This includes multi-craft supervisors. However, if contributions on my behalf are made to another construction trade and not to a laboring fund, the work is not disqualifying *(unless I am truly laboring and my hours are due to a laboring fund)*. Laboring for non-union employers is also considered Disqualifying Employment while I am under Regular Retirement Age; however, it is permitted after I reach Regular Retirement Age. I understand that my Regular Retirement Age is determined based on my work history and may be age 60, 62, or 65.

Working Restrictions Based on Age

<u>*Before Regular Retirement Age*</u> - My monthly pension benefit will be suspended for any month in which I work in Disqualifying Employment, regardless of how many hours I work. Even one hour of Disqualifying Employment before Regular Retirement Age will result in a suspension of my pension benefit.

<u>*After Regular Retirement Age*</u> - My monthly pension benefit will be suspended for any month in which I work 40 hours or more in Disqualifying Employment. Working less than 40 hours of Disqualifying Employment in a month will not affect my pension benefit.

Retiree Insurance

If my monthly pension benefit is suspended due to Disqualifying Employment and I elect 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.)*

(Certification continued on page 6)

(Certification continued from page 5.)

Notifying the OLFBP Fund Office

If I begin to work in Disqualifying Employment, I must submit written notification to the OLFBP Fund Office within 30 days of starting any potential Disqualifying Employment. If I am not sure if a particular job is considered Disqualifying Employment, I know to contact the OLFBP Fund Office for a determination. I may need to provide a job description from my employer for this determination. The Fund Office may request reasonable information from me and my employer at any time to verify my employment and the number of hours I am working.

Work that does Not Affect My Pension Benefit

The following employment is permitted and does not affect my pension or retiree insurance benefits: (1) employment outside the construction industry; (2) employment in a construction trade other than Laboring; (3) employment outside of Ohio (even Laboring), except in Boone, Campbell, and Kenton counties in Kentucky and Brooke and Hancock counties in West Virginia *(However, if I work outside of Ohio and have hours and fringes transferred to this Fund through reciprocity or from pipeline work, this would be considered Disqualifying Employment)*; and (4) any employment after age 70½ (even Laboring, regardless of the number of hours worked).

By signing this Certification, I hereby apply for a pension benefit from the Laborers' District Council and Contractors' Pension Fund of Ohio. The enclosed statements are true to the best of my knowledge and belief. I certify that I have read and understand the above Rules on Employment After Retirement and acknowledge there are additional rules and provisions in the Plan Document and Summary Plan Description that may affect 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 Contractor's 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**

Witness' Signature **Date**

Name of Witness *(print)*