

UFCW — EMPLOYERS BENEFIT PLANS OF NORTHERN CALIFORNIA

DRAWER 9000 • WALNUT CREEK, CALIFORNIA 94598-0900 • (925) 746-7530 • (800)794-5678

**INSTRUCTIONS FOR
COMPLETING AN APPLICATION FOR
RETIREMENT BENEFITS**

Complete *both sides* of the application in its entirety and sign the Authorization to obtain earnings data from the Social Security Administration. File the application and Authorization immediately with the Fund Office even though you may need further time to obtain some of the required documents. Forward the necessary documents to the Fund Office as soon as possible. The date the application is received may affect your eligibility for retro-active benefits.

Your application cannot be completed without the following documents:

1. Proof of Date of Birth of Applicant (required of all applicants).
2. Certified Copy of Marriage License and Proof of Date of Birth of Spouse, if married.
3. If filing for Social Security Adjustment Option, obtain a letter from your local Social Security Administration office stating the estimated retirement benefit you will receive at age 62, or if you desire, you may elect to use the standard average estimate calculated by the Fund Office.
4. If filing for Disability Retirement benefits, provide a copy of the Social Security Award Certificate issued to you stating your date of entitlement to Social Security Disability benefits.
5. If filing for Surviving Spouse benefits, as the legal surviving spouse of a vested member or retiree, attach a certified copy of the Death Certificate of the deceased member. Please complete this form as the Applicant for benefits and provide all available information regarding the Industry Employment of the deceased member.
6. Signed Authorization to Obtain Earnings Data from the Social Security Administration.

**PLEASE TYPE OR PRINT (USE BALL POINT PEN) – PRESS FIRMLY SO AS
TO MAKE ALL COPIES LEGIBLE.**

**YOUR INITIAL RETIREMENT AWARD CHECKS, ONCE ISSUED, WILL BE FORWARDED
TO YOUR UNION LOCAL OFFICE. THEREAFTER, THEY WILL BE MAILED
TO YOUR DESIGNATED MAILING ADDRESS.**

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RETIREMENT APPLICATION

UFCW-NORTHERN CALIFORNIA
EMPLOYERS JOINT PENSION PLAN

RETAIL CLERKS
SPECIALTY STORES
PENSION FUND

NO. CALIF. PHARMACISTS,
CLERKS & DRUG
EMPLOYERS PENSION FUND

APPLICANT'S NAME		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOC. SEC. NUMBER
STREET ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP	ALL OTHER NAMES (including maiden name)
AREA CODE & TELEPHONE NUMBER ()			
DATE OF RETIREMENT	LAST DAY ACTUALLY WORKED		LAST EMPLOYER
SPOUSE'S NAME		HAS THE MEMBER EVER WORKED IN THE INDUSTRY OUTSIDE NORTHERN CALIFORNIA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SPOUSE'S DATE OF BIRTH	DATE OF MARRIAGE		If yes, provide location: _____ CITY STATE
SPOUSE'S SOC. SEC. NO.	SPOUSE'S PRIOR NAMES (including maiden name)		
		DATES From _____ To _____	
WERE YOU EVER DIVORCED? NO ____ YES ____			
*IF YES, PROVIDE DATE DIVORCE FINAL _____			
IF YOU WERE A UFCW UNION MEMBER, PLEASE LIST YOUR LOCAL _____			

I HEREBY APPLY FOR THE BENEFITS AS CHECKED BELOW:

- Normal** – Normal Retirement Age with Vested rights.
- Early** – Early Retirement Age with Vested rights.
- Rule of 85** – Under Normal Retirement Age with Vested Rights and sum of age and Benefit Credits total 85 or more. (Available under the UFCW-Northern California Employers Joint Pension Plan only).
- Social Security Adjustment Option** – Age 55 to 62 with Vested rights. Amount of monthly benefit will be adjusted so as to provide a level monthly income for life taking into account anticipated Social Security benefits at age 62.
- Disability** – Under Normal Retirement Age with Vested rights and receiving Social Security Disability benefits first payable prior to a break in service.
- Survivor Benefits on behalf of deceased member** – provides survivor benefits to eligible surviving spouse or dependent child of a deceased member who had attained Vested rights and had met other requirements under by the applicable Plan.

THIS DOCUMENT MUST BE SIGNED BY YOU **AND** A NOTARY PUBLIC **OR** AN AUTHORIZED UFCW UNION OFFICIAL **OR** AN AUTHORIZED FUND OFFICE REPRESENTATIVE.

I hereby certify that the information provided on this form is true and correct.

Applicant _____ Date _____

NOTARY: Subscribed and sworn by me on this Date _____.

– OR – _____ (Signature)

UNION/FUND OFFICE: _____ (Signature)
REPRESENTATIVE

_____ Date

AFFIX OFFICIAL SEAL OR UNION STAMP

EMPLOYMENT HISTORY IN INDUSTRY IN NORTHERN CALIFORNIA

NAME OF STORE/COMPANY	CITY	CLASSIFICATION (CLERK, MEATCUTTER, PHARMACIST, MANAGER, ETC.)	DATES OF EMPLOYMENT				HOURS SCHED. WEEKLY
			FROM		TO		
			MONTH	YEAR	MONTH	YEAR	
PRESENT OR LAST EMPLOYER							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

*Complete the section below for **ALL** periods of your work history during which you were not in a union position in the industry:*

REASON	FROM		TO	
	MONTH	YEAR	MONTH	YEAR
Military Service <i>(Attach form DD-214)</i>				
Illness or Injury <i>(Supply doctor's name and address below)</i> If disability began 3-1-92 or later, submit copies of State Disability or Workers Compensation benefits.				
Exempt Employment in CA _____ <small>EMPLOYER/POSITION/LOCATION</small>				
UFCW Employment outside No. CA _____ <small>EMPLOYER/LOCATION</small>				
Worked in another industry or trade _____ <small>EMPLOYER/TYPE OF WORK</small>				
Self-Employment _____ <small>TYPE OF STORE/INDUSTRY/LOCATION</small>				
Other Causes (State briefly and give dates)				

If you are not retiring directly from covered employment, indicate your work status from your last date of covered employment to the present: Please list the name of your employers, addresses, positions held and dates of employment.

AUTHORIZATION TO OBTAIN EARNINGS DATA FROM THE SOCIAL SECURITY ADMINISTRATION

TO BE FILLED IN BY FUND OFFICE ONLY

JOB #: _____

FUND: _____

NAME _____

SS# _____

DATE OF BIRTH _____

Social Security Administration
300 N. Green Street
Baltimore, Maryland 21201

Please furnish the above-named Fund, Drawer 9000, Walnut Creek, California 94598, an itemized statement of all quarterly and annual amounts of wages reported to my record for the periods specified by that organization, and the identification numbers, names and addresses of the reporting employers.

Signature of Social Security Number Holder

TO BE FILLED IN BY PENSION FUND OFFICIAL ONLY

SOCIAL SECURITY ADMINISTRATION:

Please furnish the above information for the period _____

This information is to be used only to determine initial eligibility for benefits.

Countersignature of Pension Fund Official

PLEASE RETURN WITH RETIREMENT APPLICATION