Twin City Hospital Workers Pension Plan

3001 Metro Drive, Suite #500
Bloomington, MN 55425
Telephone: (952) 814-4605 – Toll Free: (800) 535-6373 – Fax: (952) 851-3566

Dear Participant:

Pursuant to your request, enclosed is a pension application form. Please complete and return it to the above address along with copies of the following documents:

- Copy of your birth certificate or acceptable proof of age (as explained on page 4 of the application).

And, if applicable,

- Copy of your spouse's birth certificate;
- Copy of your marriage certificate;
- Copy of any Qualified Domestic Relations Order(s)

If applying for Full Disability benefits:

- Copy of your Physicians Statement or Notice of Social Security Disability Award letter.

When your application is received in our office, along with the applicable documents, it will be reviewed to ensure all required documentation has been submitted. We will request additional information as needed. Your pension benefit will be calculated and correspondence will be sent to you explaining your pension benefit options. You will need to complete the benefit option election form and accompanying forms, which should be returned to our office for final processing.

Please be aware that all documents and completed forms that we request of you in order to complete the application process, must be returned to our office as soon as possible, but certainly within six months of the date the application is received. If you fail to furnish all the information necessary to process your application, it will be denied as being incomplete.

The normal processing time for pension applications is four weeks; however, in some instances it may take longer, for instance if you fail to furnish all documents necessary to complete the application process. If you have questions or require further assistance, please do not hesitate to contact us at one of the above referenced numbers.

Thank you,

FUND OFFICE

TWIN CITY HOSPITAL WORKERS PENSION PLAN

C/O WILSON-MCSHANE CORPORATION
3001 METRO DRIVE, SUITE #500, BLOOMINGTON, MN 55425
Telephone: (952)-814-4605– Toll Free: (800)-535-6373 – Fax: (952)851-3566

APPLICATION PACKAGE FOR RETIREMENT OR DISABILITY BENEFITS

You are encouraged to review the Summary Plan Description (SPD) booklet that describes all of the benefits, requirements and rules of the Plan. If you do not have a copy of the booklet, contact the Fund Office and a copy will be mailed to you. Read the material in the booklet so that you will be familiar with the provisions of the Pension Plan.

Complete this application form in its entirety. If any portion of the application does not apply to you, please so indicate by "n/a". Do Not leave any part of the application blank. Failure to properly complete the application and provide the required attachments could delay the processing of the application. If you require assistance or have questions concerning any aspect of your benefits, do not hesitate to contact the Fund Office.

INSTRUCTIONS

1) Read all questions carefully.
2) **Type or print** all answers in ink.
3) Answer all questions. (If an item does not apply, mark "n/a").
4) Attach additional sheets if necessary.
5) Be sure to date and sign the application.
6) Mail completed application along with all required attachments to the Fund Office at the above address.
7) **Make sure you attach all applicable documents. (See list on page 3.)**

PERSONAL INFORMATION

Name	
Social Security Number	
Address	
City, State, Zip	
Telephone Number	
Alternate Telephone Number	
E-mail Address	
Date of Birth (Attach proof of age. See list on page 3.)	

MARITAL INFORMATION

Marital Status (Attach copy of, as applicable, marriage certificate, death certificate, divorce decree & QDRO.)	☐ Single ☐ Divorced*, not remarried ☐ Widowed ☐ Married ☐ Remarried, with prior divorce*
Spouse's Name	
Spouse's Social Security Number	
Spouse's Date of Birth (Attach proof of age. See list on page 3.)	
*If DIVORCED, does a QDRO (Qualified Domestic Relations Order) exist?	☐ Yes ☐ No (Note: If Yes, please provide copy of Divorce Decree and QDRO.)

Print Name of Applicant/Participant: _____

TYPE OF PENSION BENEFIT APPLYING FOR

You may apply for a Retirement Benefit or a Disability Benefit.

☐	Retirement	You are eligible for a Normal, Early or Late retirement benefit depending on your age and service credits. You will be informed about each benefit you are eligible to receive.
☐	Disability	Under the Pension Plan, you may be eligible for a Disability Pension if you meet the Plan's age and service requirements. Attach a copy of your Physicians Statement or Social Security Award of Disability.

RETIREMENT DATE

Planned Retirement Date:	

PRESENT EMPLOYMENT

1) Are you currently working in the hospital industry? ☐ Yes ☐ No
2) If **Yes**, please provide the name, address and phone number of your present employer and the last day worked or expected last day worked:
Employer Name:
Address:
City, State, Zip:
Phone Number:
Last Day Worked or Expected Last Day Worked:
If **No**, please provide month and year last worked in Covered Employment:

Are you currently working in the hospital industry for an employer not covered by the SEIU Healthcare collective bargaining agreement? ☐ Yes ☐ No

If yes, list the name of your current employer _____.

- Have you had any breaks in service? ☐ Yes ☐ No

Have you ever been employed in Contiguous Non-Covered Services? ☐ Yes ☐ No

If you answer yes to the above question, please provide company names and dates in the Employment History section on page 3.

Print Name of Applicant/Participant: _____

EMPLOYMENT HISTORY

Describe the nature of the interruption in your employment.	Employer Name	From Month/Year to Month/Year

MILITARY RECORD

Did you serve in any branch of the Armed Forces of the United States: ☐ Yes ☐ No
If **Yes**, please attach a copy of your discharge papers.

INDICATE WHEN YOU SERVED:

National Emergency ☐ Yes ☐ No
or
Pursuant to a National Conscription Law ☐ Yes ☐ No
or
In time of War ☐ Yes ☐ No

Please provide dates of service: _____

Military service branch: _____

I understand that benefits will not be paid prior to actual retirement and if this application is approved, monthly benefits will commence as soon as possible after all required certifications, documents and records have been furnished to the Trustees.

I hereby certify and affirm that the foregoing statements are true, correct and complete to the best of my knowledge and belief. I understand that a false statement may disqualify me for any pension benefits and that the Trustees shall have the right to recover any payments made to me because of a false statement.

_____ _____

Participant's Signature **Date**

***Documents acceptable as proof of age:**	**Required Documents, as applicable:**
1) Birth Certificate. 2) Baptismal Certificate or other certified statement from a Church record. 3) Notification of registration of birth in a public registry of vital statistics. 4) Certified hospital records. 5) Certificate of a Social Security Award with date of birth. 6) Signed and Notarized statements of physician or mid-wife in attendance at birth. 7) Family Bible entry of birth information certified by a Notary Public. 8) Naturalization or immigration record or Current Passport. 9) Military Induction or Discharge papers. 10) Early life insurance policy showing date of birth or age on a specific date. 11) Census or school records showing age on a specific date ***Photocopies of any of the above documents is acceptable**	1) Proof of age. 2) Spouse's proof of age. 3) Marriage certificate. 4) Proof of common-law marriage. 5) Divorce decree. 6) QDRO - Qualified Domestic Relations Order. 7) Certified copy of Death Certificate (photo-copy). 8) Proof of Military Service. 9) Court name change document. 10) Social Security number change a specific document. 11) Social Security Award of Disability Letter. 12) Power of Attorney.

RETIREMENT DECLARATION

By my signature below, I certify that the foregoing statements and information are true to the best of my knowledge. I have read and understand that to qualify for retirement benefits under terms of the Plan I must adhere to the Plan restrictions regarding employment and have read the Suspension of Benefits notice and will adhere to the rules established by the Board of Trustees.

I acknowledge it is my responsibility to notify the Trustees, in writing through the Administrative Office, of any change in status that may affect my continuing eligibility for retirement benefits. I agree to notify the Administrative Office immediately of any change in mailing address, marital status or other event which may affect proper handling of benefits. I certify that I will adhere to the retirement requirements of the Plan.

I have read and understand my obligations to the Plan and hereby apply for retirement benefits from the Twin City Hospital Workers Pension Plan.

Participant's Signature Date