Connecticut Laborers' Annuity Fund

435 Captain Thomas Boulevard
West Haven, CT 06516-5896
Telephone: (203) 934-7991 – Toll-Free Number: 1-800-922-3240 Fax: (203) 680-3847
Website: https:www.ctlaborersfunds.com

Please complete **ALL** applicable sections, sign (both you and your spouse) in the presence of a Notary Public and return to the address shown above. If you should have any questions, please telephone the Fund Office at one of the telephone numbers listed above. If all sections are not completed, or if the form is not notarized, your application cannot be processed. When your completed application and all necessary information is received, your request will be processed within 30 to 45 days). In addition, you cannot file an application more than 90 days before your retirement date.

For Federal and State Income Tax purposes, you should be aware that this Plan is "Qualified" under the Internal Revenue Code. For information concerning the tax treatment of total or partial distributions, or rollovers into IRA's or other Plans, please refer to a qualified tax advisor.

Account balances are determined, and investment performance is applied annually as of the last day of the fiscal year (December 31st) only. The amount of the distribution paid will be based upon the balance of your account as of the previous December 31st. A second distribution will be made if contributions were received by the Fund in the calendar year of your distribution, subject to any investment gains or losses attributable to those contributions, and an assessment of administrative expenses and will be paid after the next valuation provided you remain eligible to receive that distribution, typically around mid-March of the following year.

There is an administrative processing fee of $50.00. If your application is approved, $50.00 will be deducted from your account prior to payment to you. This processing fee will only be assessed once per application. Should you have a remaining balance in your account (for contributions received between the December 31 immediately preceding your distribution, and the date of your distribution) and that balance is automatically paid subsequently to you, that distribution will not be assessed a processing fee.

Note: As used in this application, "Participant" refers to the individual in whose name the account is listed, and "Spouse" refers to an individual legally married to a Participant and/or an individual in a relationship with a Participant if that relationship is recognized as a valid marriage under applicable State Law.

SECTION 1 - GENERAL INFORMATION

THIS SECTION MUST BE COMPLETED BY ALL APPLICANTS

Reason for Distribution: ❒ Retirement ❒ Disability ❒ Death

❒ Termination/Withdrawal from work in Covered Employment

❒ Alternate Payee pursuant to a QDRO

❒ Attainment of Age 65

❒ Mandatory Distribution (Age 70-1/2 or Age 72)

APPLICANT'S INFORMATION
(Please Print)

Full Name _____Local Union _____ _

Street Address_____

_____ _____ _____
City State Zip Code

Email address: _____ Tel No.: _____

Social Security No. _____ Date of Birth_____

Marital Status: ❒ Married ❒ Single (Never Married) ❒ Divorced ❒ Widowed

Regardless of the country where you reside, are you a United States Citizen? ❒ Yes ❒ No

If you are not a US citizen, please indicate your country of citizenship. _____

What is your country of residence for tax purposes? _____

IF YOU ARE A UNITED STATES CITIZEN OR IF YOU ARE A RESIDENT ALIEN, PLEASE COMPLETE AND RETURN FORM W-9 (ENCLOSED) WITH YOUR COMPLETED APPLICATION

If you, the applicant is not the Participant, Member or Alternate Payee, please provide the following information regarding the Participant/Member:

Participant's Name_____

Your Relation to Participant _____

Participant's Social Security No._____

Participant's Date of Birth _____ Participant's Date of Death_____

SECTION 2 - ELECTION OF METHOD OF DISTRIBUTION

THIS SECTION MUST BE COMPLETED BY ALL APPLICANTS

NOTE THAT ALL PAYMENTS ARE BASED UPON YOUR ACCOUNT BALANCE AS OF THE LAST VALUATION DATE.

The current provisions of the Plan allow a Participant to receive payment, if qualified, in one of the following methods (some methods of payment may be prohibited by a QDRO):

A One Lump Sum Payment

- ❒ A-1 100% of Account Balance
- ❒ A-2 A Partial Distribution of $ _____, Leaving Any Remainder In your Account

(OPTIONS B - E ARE ONLYAVAILABLE IF THE BALANCE OF YOUR ACCOUNT EXCEEDS $5,000) If your account balance is $5,000 or less, you will be required to receive your distribution in a lump sum.

B ❒ Annual installments - you may elect to receive benefits in approximately equal annual installments over a period not to exceed fifteen (15) years. (If you choose this method, indicate the number of annual installments:_____). If you elect annual installments you must complete the beneficiary designation form included as Section 5 of this application.

C ❒ A 50% Joint and Survivor Annuity - you may elect to have monthly payments made to you for your lifetime which, upon your death, will continue to your spouse for his/her lifetime at 50% of the amount that you received. This is the normal payment form if you are married. You may also elect a 75% or 100% Joint and Survivor Annuity which will provide greater monthly payments to your spouse if you die. If you want quotes on these payment forms, please notify the Fund Office.

D ❒ A Lifetime Annuity – you may elect to have monthly payments made to you or only your lifetime. There will be no payments made to your spouse or beneficiary after your death. This is the normal payment form is you are not married.

E A Combination Payment – you may elect to receive a portion of your account as a lump sum payment with the balance paid out as either B, C or D, above. If you elect one of these combinations you must complete the beneficiary designation form included as Section 5 of this Application.

- ❒ E-1 Initial lump sum payment of $_____, and the balance in equal installments over years (see B above).
- ❒ E-2 Initial lump sum payment of $_____, and the balance as a 50% Joint and Survivor Annuity (see C above).
- ❒ E-3 Initial lump sum payment of $_____, and the balance as a Lifetime Annuity (see D above).

Proof of Age and Marriage - Attach a copy of your birth or baptismal certificate, or a certified copy with an original seal. (Photocopies are not acceptable unless certified to be true copies by a Notary or Town Clerk). All original documents will be returned promptly. If you are married, you must also provide proof of your spouse's age and proof of marriage. A list of documents acceptable for proof of age is included at the end of this application.

All married Participants who do not elect to receive their benefits at retirement as a 50% Joint and Survivor Annuity must reject it in writing with their spouse's consent. (The 50% Joint and Survivor Annuity (Option C) provides a lifetime benefit to the Participant with a lifetime benefit of 50% to the spouse should they outlive the Participant). In order to obtain payment as indicated in option A, B, D, or E, you must reject the 50% Joint and Survivor Annuity and your spouse must consent to that rejection by completing Section 4 of this application. Please review the enclosed Qualified Joint and Survivor Annuity Notice which discusses the financial impact and estimated benefits when choosing different forms of benefit payment.

SECTION 3 - VERIFICATION OF TERMINATION OF COVERED EMPLOYMENT

THIS SECTION MUST BE COMPLETED IF DISTRIBUTION IS REQUESTED DUE TO WITHDRAWAL FROM COVERED EMPLOYMENT

TERMINATION OF COVERED EMPLOYMENT- A distribution due to termination/withdrawal from work in Covered Employment cannot be made until at least three full (3) consecutive calendar months through and to the date of distribution have elapsed from the date contributions were last received on your behalf by the Annuity Fund. **If contributions are received based upon your work in Covered Employment following the three (3) months referenced above you will not be entitled to a distribution under this Section of the Plan.**

Please enter the last date of employment as a Union Laborer within the Connecticut Laborers' jurisdiction. Indicate the name of the contractor, and the city or town in which you last worked.

Date Last Worked	Name of Employer	City or Town You Worked in as a Union Laborer
________________	______________________________	________________________

After the last date you worked as a Union Laborer, have you worked in other employment?
❒ YES ❒ NO
If no, indicate source of income and reason you are not employed___________________________

If yes, please provide the following information for each employer you have worked for since last working as a Union Laborer. **YOU MAY BE REQUIRED TO SUBMIT APPROPRIATE VERIFICATION OF YOUR WORK ACTIVITY. IF YOU ARE A MEMBER OF A NEW UNION PLEASE PROVIDE THAT UNION CARD.**

Dates Worked	Name of Employer	City or Town You Worked
From:_______ To:__________	____________________________	____________________________

Title, Job Duties and Description of Work Performed: ____

Dates Worked	Name of Employer	City or Town You Worked
From:_______ To:__________	____________________________	____________________________

Title, Job Duties and Description of Work Performed: ____

Dates Worked	Name of Employer	City or Town You Worked
From:_______ To:__________	____________________________	____________________________

Title, Job Duties and Description of Work Performed: ____

Dates Worked	Name of Employer	City or Town You Worked
From:_______ To:__________	____________________________	____________________________

Title, Job Duties and Description of Work Performed: ____

SECTION 4 -WAIVER OF 50% JOINT AND SURVIVOR ANNUITY AND SPOUSE'S CONSENT TO WAIVER

NOTE: Your spouse's signature is required below unless you are not married. If not married, please provide the following:

If divorced, attach a copy of the divorce decree.

If spouse is deceased, attach a copy of the death certificate.

If never married, attach the enclosed Affidavit of Marital Status (notarized), including the-names and addresses of two (2) references that will attest.

THIS SECTION MUST BE COMPLETED BY THE SPOUSE OF ANY PARTICIPANT NOT ELECTING TO RECEIVE PAYMENT IN THE FORM OF A 50% JOINT AND SURVIVOR ANNUITY

I hereby consent to my spouse's request for payment from the Annuity Fund in the form of _____

(Insert method of distribution from Section 2 of this application) in lieu of a 50% Joint and Survivor Annuity. Further, I hereby acknowledge and understand the following:

- My consent to the waiver of the 50% Joint and Survivor Annuity means that I will forfeit my rights to a monthly benefit which I would be entitled to receive upon the death of my spouse;
- That my spouse's election of a form of payment other than a 50% Joint and Survivor Annuity is not valid unless I consent to it;
- That I do not have to sign this consent and Iam signing it voluntarily;
- That if my spouse elects an installment payment option, any designation of beneficiary is also subject to my consent; and
- That my consent is irrevocable unless my spouse revokes the waiver.

I further acknowledge that I have read and understand the document provided to me entitled "Connecticut Laborers' Annuity Plan - Explanation of Spouse's Rights Relating to Payment of Benefits."

_____ _____

Signature of Spouse Date

(MUST BE SIGNED AND DATED IN THE PRESENCE OF THE NOTARY)

Spouse's Social Security Number _____

Spouse's Date of Birth _____ Date of Marriage _____

NOTARY'S ACKNOWLEDGEMENT OF SPOUSE'S CONSENT AND WAIVER OF 50% JOINT AND SURVIVOR ANNUITY

(All items which follow on this page MUST be completed by the Notary)

State of _____

County of _____ SS: _____

On the___day of _____ 20__before me came _____known to be the person described herein and who executed the foregoing statement in my presence and duly acknowledged to me that he/she executed the same as his/her free act and deed for the purposes therein contained. In witness whereof I hereunto set my hand:

Signature of Notary Public (Raised Seal Required)

_____

My commission expires _____

SECTION 5A-DESIGNATION OF BENEFICIARY AND CONSENT TO DESIGNATION OF BENEFICIARY

THIS SECTION MUST BE COMPLETED BY APPLICANTS ELECTING A FORM OF PAYMENT OTHER THAN A JOINT AND SURVIVOR ANNUITY OR LIFETIME ANNUITY

I understand that if I am married and designate someone other than my Spouse to receive benefits payable on account of my death, my Spouse must consent to that designation. I also understand that my Spouse's consent must be in writing and witnessed by a Notary Public or Plan representative, unless I certify that I cannot locate my Spouse.

I hereby revoke all previous designations of primary and contingent beneficiary(ies) under the Connecticut Laborers' Annuity Plan (the "Plan") and direct that the amounts to which I am entitled under the Plan be paid, after my death, as follows:

Name and Address of Primary Beneficiary(ies)	Relationship	Social Security No.
_____	_____	_____
_____	_____	_____
_____	_____	_____

If more than one primary beneficiary is named, they shall share equally, unless otherwise stated. If my primary beneficiary(ies) predeceases me, or disclaims all or part of the benefits provided under the Plan, then my contingent beneficiary(ies) who will be entitled to receive amounts to which I am entitled under the Plan are as follows:

Name and Address of Contingent Beneficiary(ies)	Relationship	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

If more than one contingent beneficiary is named, they will share equally, unless otherwise stated.

If I have no surviving beneficiary(ies) when I die, my account balance will be distributed under the terms of the Plan.

The rights of the beneficiary(ies) designated on this form are subject to the terms and conditions of the Plan.

The payment of my account to the beneficiary(ies) designated on this form will be a complete and full release and discharge of the Trustees and the Fund, to the extent of that payment.
I understand that at any time I may revoke, alter or amend this beneficiary designation with either my Spouse's written consent or my certification that I am unmarried or cannot locate my Spouse. I understand that if I am now married and I later divorce and marry another person, this designation automatically will be void. If I designate a beneficiary other than my new Spouse, I must have my new Spouse's written consent, witnessed by a Notary Public. I also understand that if I am now unmarried, later marry, and then die survived by my Spouse, this designation will be invalid, and my surviving Spouse will be my beneficiary unless he or she has consented, in writing, witnessed by a Notary Public to a different beneficiary designation.

_____ _____

Date Signature of Applicant

_____

Signature of Witness

SECTION 5B - SPOUSE'S CONSENT TO DESIGNATION OF BENEFICIARY OTHER THAN SPOUSE

THIS SECTION TO BE COMPLETED BY THE SPOUSE ONLY IF THE SPOUSE IS NOT DESIGNATED AS THE BENEFICIARY

I hereby certify that I am the Spouse of the above-named participant and I have read the Designation of Beneficiary Section (Section 6A) of this application as completed and signed by the Participant. I understand that, upon the Participant's death, I am entitled to any unpaid Plan benefits unless I consent to the Participant's designation of a non-Spouse beneficiary. In granting this consent, I understand that I am waiving any right I might have to any benefit under the Plan if the Participant dies, except to the extent that he or she may name me specifically as a Beneficiary. The designated beneficiary(ies) may not be changed at any time during which I am married to the Participant (except to designate me as his or her sole primary beneficiary) without my written consent on a form supplied by the Fund Office.

_____ _____

Signature of Spouse Date

(MUST BE SIGNED AND DATED IN THE PRESENCE OF THE NOTARY)

NOTARY'S ACKNOWLEDGEMENT TO SPOUSE'S CONSENT TO DESIGNATION OF BENEFICIARY OTHER THAN SPOUSE

State of_____

County of _____ SS: _____

On_____ day of _____ , 20 before me came_____

_____ known to be the person described herein and who executed the foregoing statement in my presence and duly acknowledged to me that he/she executed the same as his/her free act and deed for the purposes therein contained. In witness whereof I hereunto set my hand:

_____

Signature of Notary Public (Raised Seal Required)

My commission expires _____

SECTION 6- ELECTION OR REJECTION OF DIRECT ROLLOVER TO AN IRA OR RETIREMENT PLAN

THIS SECTION MUST BE COMPLETED ONLY IF YOU WILL RECEIVE A PAY OUT IN A LUMP SUM; OR OTHER ELIGIBLE ROLLOVER DISTRIBUTION

NOTE: **BEFORE COMPLETING THIS SECTION, YOU SHOULD READ THE SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS CAREFULLY. YOU ALSO MAY WISH TO CONSULT YOUR TAX ADVISOR BEFORE MAKING THIS ELECTION.**

If you receive part or all of your account balance as an "eligible rollover distribution", you may elect to have part or all of that distribution transferred directly to an Individual Retirement Account (IRA) or to another qualified retirement plan (if it accepts rollovers), **If this is the case please provide a "Letter of Acceptance" from your Rollover Company.** .If you choose not to have an eligible rollover distribution transferred directly to an IRA or other retirement plan, the Plan is required to withhold 20 percent of the payment for federal income taxes, and if applicable 7 percent for the Connecticut income taxes. This withholding does not increase your taxes but will be credited against any income tax you owe. (For further information on direct rollovers and withholding, please read the Special Tax Notice Regarding Plan Payments that the Plan has given you).

COMPLETE SECTION 6A or 6B BELOW TO INDICATE WHETHER OR NOT YOU ELECT A DIRECT ROLLOVER OF YOUR ANNUITY ACCOUNT BALANCE:

SECTION 6A - TO ELECT A DIRECT ROLLOVER OF SOME OR ALL OF YOUR DISTRIBUTION

❒ I want to roll over my entire payment directly to an IRA or other qualified retirement plan that accepts rollovers. The IRA or other retirement plan is named below.

_____ _____
Name of Trustee or Qualified Retirement Plan — Account Number

OR _____
Mailing Address

❒ I would like to have only part of my payment directly rolled over. Please roll over $_____to the IRA or qualified retirement plan named below, and pay the remainder of my benefit to me, after withholding 20 percent for federal income taxes and State of Connecticut income tax withholding, if applicable.

_____ _____
Name of Trustee or Qualified Retirement Plan — Account Number

_____
Mailing Address

I certify that the recipient of a direct rollover that I have named above is an Individual Retirement Account, or a qualified retirement plan that accepts rollovers. I understand that payment of my benefits to the trustee of the IRA or qualified retirement plan will release the Trustees of the . Connecticut Laborers' Annuity Fund from any further obligations or responsibilities with respect to the benefits so paid.

_____ _____
Signature of Applicant — Date

SECTION 6B - TO REJECT ANY DIRECT ROLLOVER

❒ I do not want to roll over any of my payment directly to an IRA or other qualified retirement plan. Pay me the full amount of my benefits, after withholding 20 percent for federal income taxes as required by law and any required state income tax withholding.

_____ _____
Signature of Applicant — Date

SECTION 7- AFFIRMATION AND CONSENT

THIS SECTION MUST BE COMPLETED BY ALL APPLICANTS

I hereby represent that the information provided by me in this application is correct to the best of my knowledge and I request payment as I have indicated. I understand that payment may not be made to me prior to April 1 of the year following the year in which I attain age 70-1/2 (age 72 for some members) without my consent, and I expressly consent to the receipt of a distribution at the current time. I acknowledge that Once payment has commenced, I may not change the method of distribution. In addition, I hereby attest that I have retired from, and/or I am not engaged in, employment as a laborer in any phase of the construction industry within the State of Connecticut.

_____ _____

Signature of Applicant Date

(MUST BE SIGNED AND DATED IN THE PRESENCE OF THE NOTARY)

NOTARY'S ACKNOWLEDGEMENT TO AFFIRMATION AND CONSENT

(All items which follow on this page **MUST** be completed by the Notary)

State of_____

County of _____ SS_____

On the_____ day of _____,20 _____

Before me came _____ known to be the person described herein and who executed the foregoing statement in my presence and duly acknowledged to me that he/she executed the same as his/her free act and deed for the purposes therein contained. In witness whereof I hereunto set my hand:

_____

Signature of Notary Public (Raised Seal Required)

My commission expires _____

SECTION 8 – DISABILITY INFORMATION

THIS SECTION MUST BE COMPLETED IF DISTRIBUTION IS BASED UPON DISABILITY

SINCE IT IS THE RECEIPT OF A COMPLETED APPLICATION WHICH WILL DETERMINE THE EARLIEST POSSIBLE EFFECTIVE DATE FOR ANY BENEFITS WHICH MAY BECOME PAYABLE, YOU MAY WISH TO SUBMIT THE APPLICATION AS SOON AS POSSIBLE EVEN IF THE MEDICAL INFORMATION CANNOT BE SUBITTED AT THE SAME TIME. IF YOU SUBMIT THE APPLICATION WITHOUT THE MEDICAL EVIDENCE IT IS REQUIRED THAT THE MEDICAL EVIDENCE BE SUBMITTED WITHIN A REASONABLE TIME AFTER SUBMISSION OF THE APPLICATION.

THE EFFECTIVE DATE FOR A DISTRIBUTION DUE TO DISABILITY CANNOT BE ANY EARLIER THAN SIX MONTHS AFTER YOUR DISABILITY BEGAN (THE DATE YOU WERE OBLIGED TO CEASE WORK) OR THE FIRST DAY OF THE SEVENTH (7^{TH}) CALENDAR MONT AFTER THE MONTH THE SOCIAL SECURITY ADMINISTRATION DETERMINED YOU TO BE DISABLED.

Is your disability work related? ❒ YES ❒ NO

If yes, please provide the name and address of the employer at the time of injury, the date of injury, the nature of the disability and the type of work you were usually performing for the employer.

Employer's Name: _____

Address: _____

Date of Injury: _____ Type of Work: _____

Description of Disability: _____

Is your disability work related to military service? ❒ YES ❒ NO

If yes, please provide the branch of the Armed Forces in which you served; date of initial onset of injury/illness and the nature of your disability.

Branch of Armed Forces: _____

Date of initial onset of injury/illness: _____

Description of Disability: _____

If your disability is not work related or related to military service, pleas provide the date you first became disabled and the nature of your disability

Date you first became disabled: _____ Nature of Disability: _____

If your disability is related to an accident, please describe the circumstances of the accident:

_____

_____

Name and address of the physician who attended you when your disability occurred.

Name: _____

Address: _____
Street City and State Zip Code

If you are not currently seeing the same physician, provide the name address of the physician now attending you.

Name: _____

Address: _____
Street City and State Zip Code

Have you applied for Social Security Benefits: ❒ Yes ❒ No

❒ I have received a response from the Social Security Administration. (Please provide a copy of their determination letter).

❒ I have not received a response from the Social Security Administration.

If you have not received a determination from the Social Security Administration or if you do not intend to apply for Social Security Disability Benefits, please contact the Fund Office to inquire about the type of medical information which must be provided for an Occupational Disability.

SPECIAL NOTE: Research may be required as a result of your application for which the Fund will have to make inquiries. Therefore, we would appreciate your signing the following authorization to release information.

MEDICAL AUTHORIZATION

(Disability Applicants Only)

I authorize the holder of any medical information concerning my physical condition, including, but not limited to, the results of any physical examination or tests conducted, or any hospital records, to release to the Connecticut Laborers' Annuity Fund or its representative, any and all such information which I understand is required to complete my claim for a distribution based on disability made to the Connecticut Laborers' Annuity Fund. A copy of this authorization may be used in place of the original. I understand that this information will be used by the Board of Trustees of the Connecticut Laborers' Annuity Fund solely to complete my claim as required by the Connecticut Laborers' Annuity Fund.

_____ _____
Signature of Applicant Date

LIST OF ACCEPTABLE DOCUMENTS FOR PROOF OF AGE

1. You may submit one (1) of the following for you and your spouse, if applicable:

   A BIRTH CERTIFICATE (copy acceptable)

   VALID DRIVER LICENSE (copy acceptable)

   A BAPTISMAL CERTIFICATE (copy acceptable)

   A STATEMENT AS TO THE DATE OF BIRTH shown by a church record, certified by the custodian of such record. (copy acceptable)

   NOTIFICATION OF REGISTRATION OF BIRTH in a public registry of vital statistics. (copy acceptable)

   CERTIFICATION OF RECORD OF AGE by the United States Census Bureau. (copy acceptable)

   HOSPITAL BIRTH RECORD certified by the custodian of such record. (copy acceptable)

   FOREIGN CHURCH OR GOVERNMENT RECORD. (Original Required)

2. If you do not have one of the above documents, you must submit TWO (2) of the following:

   MILITARY RECORD (Original Required)

   PASSPORT (Original Required)

   SCHOOL RECORD certified by the custodian of such record. (copy acceptable)

   AN INSURANCE POLICY which shows the age or date of birth. (copy acceptable)

   MARRIAGE RECORDS SHOWING DATE OF BIRTH OR AGE. Application for marriage license or church record, certified by the custodian of such record; or marriage certificate. ***Required by all married participants***. (copy acceptable)

   OTHER EVIDENCE such as signed statements from persons who have knowledge of the date of birth, tax return, etc.

   A SIGNED STATEMENT BY THE PHYSICIAN OR MIDWIFE who was in attendance at birth, as to the date of birth shown on their records. **(Original Notarized Document Required)**

   NATURALIZATION RECORD (Original Required)

   IMMIGRATION PAPERS (Original Required)

LIST OF ACCEPTABLE DOCUMENTS FOR PROOF OF MARRIAGE

Marriage Records certified marriage certificate or church record (certified by the custodian of such record) (copy acceptable)

NOTE: In all cases where a copy is acceptable, an original document may be required, at the Fund Office's discretion.