CEMENT MASONS & PLASTERERS LOCAL UNION #518 DEFINED CONTRIBUTION PLAN

Administered by: Wilson-McShane Corporation
PO Box 909500 Kansas City, MO 64190-9500
(877) 518-0518 www.kcmasonsbenefits.org

Dear Participant:

Attached is the Application for Benefits you requested from the Cement Masons & Plasters Local 518 Defined Contribution Plan. Please review the following information carefully to make sure you meet the requirements and have included all information so we can process your request in a timely manner.

In order to qualify for payment of your benefit, you must meet one of the following requirements:

- At least age 55;
- Under age 55, provided that you have not worked in any disqualifying employment in twelve consecutive months and have ceased industry employment;
- If you are totally and permanently disabled [proof of disability is required];
- Payment to your beneficiary upon your death.

This form requires a copy of the Members and Spouse State issued identification.

- Drives License
- State ID

The Member AND Spouse must supply one form of documentation from the following list that verifies his or her date of birth along with a marriage certificate:

- Birth Certificate
- Naturalization Records
- Immigration Papers
- Military Records
- Social Security Records (NOT CARD)
- School Records
- Vaccination Records
- Marriage Records indicating date of birth

We have included the following forms for your review and completion:

- **EKON ELECTION FORM AND DIRECT DEPOSIT AUTHORIZATION**
- **FORM A – APPLICATION FOR DEFINED CONTRIBUTION PLAN BENEFITS**
- **FORM B – PAYMENT ELECTION FORM**

All forms must be completed and signed where indicated. Failure to provide all completed forms and supporting documentation could cause a delay in your file processing.

If you have any questions, please contact the Fund Office at (877) 518-0518.

FORM A – APPLICATION FOR DEFINED CONTRIBUTION PLAN BENEFITS

Name: _____ Local Union #: _____

Social Security Number: _____ Phone Number: _____

Address: _____
Street *City* *State* *Zip Code*

Date of Birth: _____

Current Marital Status: ☐Single, Never Married ☐Single, Previously Married*

☐Married, No Previous Marriages ☐Married, With Previous Marriage(s)*

☐Legally Separated*

*If you were previously married, please list for each ex-spouse, name, date of marriage and date of divorce (or, if you were married and your spouse died during that marriage, the date of death):

Ex-spouse's Name	Date of Marriage	Date of Divorce/Death

(If divorced or legally separated, attach copy of Divorce Decree and Property Settlement Agreement or Order of Legal Separation.)

Spouse Information

Name of Spouse (Beneficiary): _____

Spouse/Beneficiary Social Security Number: _____ Spouse Date of Birth: _____

Employment Information

Last Employer: _____ Last Date Worked: _____

Please list all employers in the last twelve months and the dates employed:

Name of Employer	Employer Address	Dates Employed

Why do you believe you are eligible to receive a benefit? Check all that apply?

☐ I am at least age 55;

☐ I am totally and permanently disabled;

☐ I am under age 55 and have not had any contributions paid on my behalf for at least twelve consecutive months and have ceased industry employment;

☐ I am a beneficiary applying for a death benefit;

If you are applying for a Disability Pension, please complete the following:

Have you applied for Social Security? ☐YES ☐NO (Attach copy of Disability Award Letter)

Nature of disability: _____ Date you became disabled: _____

If you do not have a Social Security Disability Award, please attach disability reports from two separate physicians.

I hereby certify to the Board of Trustees the above statements are true to the best of my knowledge. This application revokes any previous beneficiary designation.

_____ _____

Applicant's Signature **Date**

I, _____, do hereby certify that _____, the above-named participant, personally appeared before me, provided documentation to support his/her identity, signed the application and acknowledged the same to be his/her own free act and deed.
Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Signature of Notary Public
Affix notary seal in space to right

Spousal Consent

I,_____ (name of spouse), am the spouse of _____ (name of participant).
I agree that my spouse can receive retirement benefits in the form selected above. If applicable, I also agree to my spouse's choice of the beneficiary designated above will receive any survivor benefits that may be payable from the Plan after my spouse dies. I understand that my spouse cannot choose a different form of retirement benefits or a different beneficiary unless I agree to the change. I understand I have the right to revoke this Agreement only until benefit payments are scheduled to begin. I understand that I do not have to sign this Agreement. I am signing this Agreement voluntarily.

_____ _____

Signature of Spouse **Date**

I, _____, do hereby certify that _____, the above-named spouse, personally appeared before me, signed the Spousal Consent Agreement and acknowledged the same to be his/her own free act and deed.
Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Signature of Notary Public
Affix notary seal in space to right

FORM B – PAYMENT ELECTION FORM

Attention: Before completing this form, you should read the Special Tax Notice regarding Play Payments carefully. You may also wish to consult your tax advisor before making this election.

If you will receive part or all of your benefits as an "eligible rollover distribution", you may elect to have a part or all of that distribution transferred directly to an Individual Retirement Account (IRA) or another qualified retirement plan (if it accepts rollovers).

If you choose not to have an eligible rollover distribution transferred direction to an IRA or other retirement plan, the Plan is required to withhold 20% of the payment for federal income taxes. This withholding does not increase your taxes, but will be credited against any income tax you owe.

Check below to indicate whether or not you elect a direct rollover of your pension payment:

_____ I DO NOT want to rollover any of my payment to an IRA or other qualified retirement plan. Pay me the full amount of my benefit after withholding 20% for federal income taxes, as required by law.

_____ I want to rollover my payment directly to an IRA or other qualified retirement plan that accepts rollovers. The IRA or other qualified retirement plan is listed below.

_____ _____
Applicant's Signature Date

_____ _____
Spouse/Beneficiary Signature Date

IRA OR OTHER QUALIFIED RETIREMENT PLAN INFORMATION

Name of Trustee/Qualified Retirement Plan: _____

Payee: _____

Address: _____
Street *City* *State* *Zip Code*

Account Number: _____

Return completed application and supporting documents to:
Cement Masons & Plasterers Local Union #518
PO Box 909500 Kansas City, MO 64190-9500
(877) 518-0518 www.kcmasonsbenefits.org