Your Pension Commencement Date is determined by the date your Retirement Application is received by the Plans Office. The **ORIGINAL** application must be received in the Plans Office before payments will be released. Please allow **a minimum of 6 weeks** to process your application. If applying for Normal Retirement benefits, please use a Normal Retirement Application.

DISABILITY RETIREMENT APPLICATION
ILWU-PMA PENSION PLAN ◆ ILWU-PMA WATCHMEN PENSION PLAN

1. Legal Name:_____
First *Middle* *Last*

Local:_____ Registration Number:_____

2. Address:_____
Street

_____
City ***State*** ***Zip Code***

Telephone Number: (_____)_____ Email:_____

3. Social Security No.:_____

Birth date:_____ Age:_____

4. *(**NOTE:** This question does not apply to Watchmen.)* List all the periods during which you did not work in covered employment due to an industrial illness or injury arising out of employment in the longshore industry for which you received compensation in the form of state or federal workers' compensation (including third party suit settlement).

DATE OF DISABILITY	TYPE OF COMPENSATION RECEIVED	PERIODS FOR WHICH YOU RECEIVED COMPENSATION

5. WITH REGARD TO YOUR PRESENT DISABILITY:

Name of doctor(s) treating you:

Doctor_____ Address_____

Telephone# (_____)_____

Doctor_____ Address_____

Telephone# (_____)_____

(If more space is needed, attach separate piece of paper.)

(a) Do you grant permission for the trustees or their agents to contact your doctor(s) concerning your disability? YES ☐ NO ☐

(b) Do you agree to undergo whatever medical examination the trustees may require? YES ☐ NO ☐

(c) Have you received or are you currently receiving any type of compensation in connection with your present disability? YES ☐ NO ☐

If YES:

(OVER)

APPROXIMATE DATES

☐ Federal workers' compensation From_____ To_____

☐ State workers' compensation From_____ To_____

☐ California State Disability Insurance From_____ To_____

☐ ILWU-PMA Welfare Plan Weekly Indemnity Benefits From_____ To_____

6. Date you last worked as a Longshoreman, Ship Clerk, Walking Boss/Foreman, or Watchman:

_____

SURVIVOR BENEFITS

In case of your death, your spouse may be entitled to survivor benefits. Please fill in the following information for future reference:

Current Marital Status: ☐ Legally Married ☐ Single (Never Married)
☐ Divorced ☐ Widowed

Evidence of marital status must be submitted as applicable: photocopy of certified marriage certificate, divorce decree, death certificate. If currently legally married, please complete the following:

Spouse's Legal Full Name _____

Spouse's Address _____
Street

(If different from Applicant's address.) _____
City *State* *Zip*

Spouse's Birthdate _____ Spouse's Social Security No. _____

IMPORTANT: The Benefit Plans Office will notify you when your application is received. Contact the Plans Office if you do not receive this confirmation within two weeks of the date your application was submitted.

I hereby certify that the above information is correct to the best of my knowledge and belief. I acknowledge that as of my Separation Date certified by the Trustees, I will be permanently separated from all employment under a Longshore or Watchmen industry Collective Bargaining Agreement, and that my name will be permanently removed from all Longshore or Watchmen industry registration lists.

_____
Signature Date

To expedite review, FIRST submit application via...

Fax: (415) 749-1321 ***OR***

Email: pension@benefitplans.org

...THEN mail application to

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

ILWU-PMA PENSION PLAN • ILWU-PMA WATCHMEN PENSION PLAN

DISABILITY RETIREMENT MEDICAL REPORT

DOCTOR'S CONTACT INFO:

NAME:
ADDRESS:
CITY, STATE, ZIP:
PHONE NUMBER:

☐ Kaiser Health Plan

☐ Indemnity Plan

PLEASE SEND COMPLETED ORIGINAL FORM TO:
ILWU-PMA BENEFIT PLANS - 1188 FRANKLIN STREET - SUITE 101 - SAN FRANCISCO, CA 94109

PATIENT NAME	LOCAL	REG. NO.

TO BE COMPLETED BY ATTENDING PHYSICIAN. PLEASE ANSWER ALL QUESTIONS:

1) Is the patient totally and permanently disabled for his regular work in the longshore or watchmen industry? ..... YES ☐ NO ☐

   a) **IF YES**, on what date did patient become totally and permanently disabled for his regular work? _____

   b) On what date did you reach this conclusion? _____

2) Is the disability wholly attributable to an industrial injury? ..... YES ☐ NO ☐

3) On what date, according to your records, did illness begin or the disabling injury occur? _____

4) Is treatment continuing? _____

5) Date patient last seen? _____

6) Completely describe in the space below a summation of medical condition, diagnoses, and the physiological limitations or impairment.

OR

7) Submit written documentation (narrative, medical summaries, legible office notes, pertinent laboratory and/or test results, etc.) that provide the medical reviewer with sufficient information to make an independent decision.

☐ **CHECK BOX IF DOCUMENTS ARE ATTACHED**

Examining Doctor: _____
PRINT NAME **SIGNATURE** **DATE**

TO BE COMPLETED BY PENSION PLAN REVIEWING DOCTOR:

☐ I concur with the conclusions of the examining doctor.
☐ I do not concur with the conclusions of the examining doctor.

_____
Signature of Plan Reviewing Doctor **Date**

PATIENTS' RELEASE

I hereby authorize the release of information from and concerning my medical records to the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan trustees, their agents, their consulting physicians and my ILWU Local.

_____
Signature of Patient **Date**

ILWU-PMA PENSION PLAN
ILWU-PMA WATCHMEN PENSION PLAN

NOTICE TO RETIREMENT APPLICANTS

SUBJECT: Income Tax Withholding

Any pension payments you become entitled to receive under the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan, including disability pension payments, will be subject to federal income tax withholding unless you elect to the contrary. Please complete and return the enclosed Federal Election Form to make your wishes known with respect to federal income tax withholding.

If you want to have federal income taxes withheld from your pension payments, please complete Federal Election Form Part I. If you make an election to have withholding, it will remain in effect until revoked by you.

If you do not want to have taxes withheld from your pension payments, please complete Federal Election Form Part II. If you make an election to have no withholding, it will remain in effect until revoked by you. We are required to inform you that if you elect out of withholding or if you do not have enough income tax withheld, you may be responsible for payment of estimated tax. You may be subject to penalties under IRS estimated tax rules if your withholding and estimated tax payments are not sufficient.

If you do not submit a Federal Election Form, federal income tax will be withheld from your pension payments as if you are a married person claiming three withholding allowances. Under this provision, there currently is no withholding on pension payments of **$2,100.00** per month or less.

You will be able to change your federal income tax withholding at any time by submitting a new Federal Election Form. If you are found eligible for retirement, we will enclose with your certification letter instructions on how to change the withholding amount if you wish.

SUBJECT: California Income Tax Withholding - **FOR CALIFORNIA RESIDENT ONLY**

If you wish to have California tax withholding, you must also complete the enclosed California Election Form. If you do not submit the California Election Form, state income tax will be withheld from your pension payments as if you are a married person claiming three withholding allowances. Under this provision, there currently is no withholding on pension payments of **$3,040.00** per month or less.

ILWU-PMA BENEFIT PLANS ♦ 1188 FRANKLIN STREET, SUITE 101 ♦ SAN FRANCISCO, CA 94109
Phone: (415) 673-8500 Fax: (415) 749-1321 Email: pension@benefitplans.org

FEDERAL ELECTION FORM

Complete Part I or Part II. **DO NOT COMPLETE BOTH PARTS.**

PART I. Complete Part I only if you want to have federal income taxes withheld from your pension payments.

YES, I want to have federal income taxes withheld from my pension.

☐ Single ☐ Married Number of allowances _____

(BLANK FIELD = ZERO (0) ALLOWANCES)

Additional amount, if any, you want deducted from each payment $_____

You can claim the following allowances:

- 1 for yourself;
- 1 for your spouse if you are married;
- 1 for each additional dependent you will claim on your federal income tax return.

NOTE: PER IRS Regulations: You must specify a filing status and a number of withholding allowances. You cannot specify only a dollar amount of withholding. Please refer to https://www.irs.gov or your Tax professional for further information.

Other allowances may also be claimed; allowances may be higher if you or your spouse are over age 65 or are blind, or if you itemize deductions. The IRS or your own tax adviser can give you a worksheet to help you figure your withholding allowances.

_____ _____ _____

Signature of Pensioner or Survivor PRINT NAME HERE Date

_____ _____ (_____) _____

Local Reg. No. **Telephone Number (optional)**

*** PART II FOR EXEMPT PURPOSES ONLY ***

PART II. Complete Part II only if you do not want to have federal income taxes withheld from your pension payments. Do not complete Part II if you are a U.S. citizen receiving your pension payments outside the United States.

☐ I elect not to have federal income taxes withheld from my pension. I understand that I can revoke this election at any time.

You should be aware that your pension benefits are taxable income. If you elect not to have tax withheld, you may be subject to penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

_____ _____ _____

Signature of Pensioner or Survivor PRINT NAME HERE Date

_____ _____ (_____) _____

Local Reg. No. **Telephone Number (optional)**

California Residents - If you want to have California tax withholding as well, you must also complete an Election Form for the State of California.

RETURN FORM TO: ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

Fax: (415) 749-1321
Email: pension@benefitplans.org

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Phone: (415) 673-8500 Fax: (415) 749-1321 Email: pension@benefitplans.org

STATE OF CALIFORNIA ELECTION FORM

PART I. *Complete Section A or Section B. Do not complete both Sections.*

A. I want my withholding from each pension payment to be figured using the marital status and number of withholding allowances shown below:

☐ Single ☐ Married ☐ Unmarried Head of Household Number of allowances _____
[BLANK FIELD = ZERO (0) ALLOWANCES]

Additional amount (if any) I want deducted from each payment: $_____

OR

B. I want this fixed amount withheld from each pension payment: $_____

_____ _____ _____
Signature of Pensioner or Survivor Local/Reg.No. Date

_____ (____) _____
PRINT NAME HERE **Telephone Number (optional)**

*** PART II FOR EXEMPT PURPOSES ONLY ***

PART II. Complete Part II only if you do not want to have California Personal Income Taxes withheld from your pension payments.

☐ I elect not to have California income tax withheld from my pension. I understand that I can revoke this election at any time.

If you elect not to have tax withheld, you should be aware that your pension benefits are taxable income. You may be subject to penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

_____ _____ _____
Signature of Pensioner or Survivor Local/Reg.No. Date

_____ (____) _____
PRINT NAME HERE **Telephone Number (optional)**

RETURN FORM TO: ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109

Fax: (415) 749-1321
Email: pension@benefitplans.org

ILWU-PMA BENEFIT PLANS
1188 FRANKLIN STREET, SUITE 101, SAN FRANCISCO, CA 94109
TELEPHONE (415) 673-8500

Dear Payee:

As an alternative to mailing you your monthly benefit, ILWU-PMA Benefit Plans (Plan office) is offering you the option of having your monthly pension check electronically deposited to your financial institution. Electronic Fund Transfer (EFT) is limited by law to those financial institutions which are banks, savings and loans, and credit unions. This is an optional program.

WHAT IS EFT?

With EFT, your pension benefit is sent electronically to your financial institution and credited directly to your account. There is no check printed or sent through the mail.

WHAT ARE THE ADVANTAGES OF EFT?

- Immediate and uninterrupted deposits during periods of absence from residence.
- Your pension benefit is credited to your account on the first banking day of each month.
- Reduced risk of loss, theft, or forgery of benefit checks.

In order to participate in EFT, complete Section 1 of the Electronic Fund Transfer Authorization Form. Have your bank complete Section 2 and send the completed form to the Plan office.

Prior to transmission of your initial EFT, you will receive an effective date notification at the home address you have on record with the Plan office.

INFORMATION AND INSTRUCTIONS

PLEASE READ THIS CAREFULLY

WHEN TO USE THE ELECTRONIC FUND TRANSFER AUTHORIZATION FORM

The authorization form should be filled out in full and signed by both you and an authorized official of your financial institution for the following purposes:

1. To sign up as a new enrollee.

2. To change Electronic Fund Transfer from checking to savings and vice versa.

3. To change Electronic Fund Transfer from one financial institution to another.

4. To change depositor account numbers within a financial institution.

(over)

WHEN WILL MY FIRST ELECTRONIC FUND TRANSFER TRANSACTION BE CREDITED TO MY ACCOUNT?

Your first transaction may occur from 60 to 90 days after your request form is received by the Plan office. You will receive notice of deposit from the Plan office prior to the first transaction.

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Plan office and the financial institution of the death of the payee. Funds deposited after the date of death are to be returned to the Plan office. The Plan office will then make a determination regarding benefits payable and beneficiary's entitlement. Failure to notify the Plan office of the death of the payee could result in substantial liability to the account holder.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the payee by written notice to the Plan office, by the death or legal incapacity of the payee, or cancelled by the Plan if benefits terminate in accordance with Plan provisions.

The agreement represented by this authorization may be cancelled by the financial institution by providing the payee a written notice 30 days in advance of the cancellation date. The payee must immediately advise the Plan office if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Plan office.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

Your Electronic Fund Transfer will continue to be received by the selected financial institution until you notify the Plan office that you wish to change the financial institution receiving the Electronic Fund Transfer. To effect this change, you must complete a new Electronic Fund Transfer Authorization Form. It is recommended that you maintain accounts at both financial institutions until the process is complete and until the new financial institution has received your first Electronic Fund Transfer.

PAYEE MUST KEEP THE BENEFIT PLANS OFFICE
INFORMED OF ANY ADDRESS CHANGES

ILWU-PMA BENEFIT PLANS
1188 FRANKLIN STREET, SUITE 101, SAN FRANCISCO, CA 94109
TELEPHONE (415) 673-8500 FAX (415) 749-1321
www.benefitplans.org

ELECTRONIC FUND TRANSFER AUTHORIZATION

TO SIGN UP FOR ELECTRONIC FUND TRANSFER, PLEASE READ THE BACK OF THIS FORM AND FILL IN THE INFORMATION REQUESTED IN SECTION 1. THEN TAKE OR MAIL THIS FORM TO YOUR FINANCIAL INSTITUTION. THE FINANCIAL INSTITUTION WILL VERIFY THE INFORMATION IN SECTION 1 AND WILL COMPLETE SECTION 2. **SEND THE COMPLETED FORM TO ILWU-PMA BENEFIT PLANS, 1188 FRANKLIN STREET, SUITE 101, SAN FRANCISCO, CA 94109.**

PAYEE MUST KEEP THE BENEFIT PLANS OFFICE INFORMED OF ANY ADDRESS CHANGES.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A Name of Payee (last, first, middle initial)	B Payee Social Security Number _____ - _____ - _____
Address (Street, Route, P.O. Box)	C Local and Registration Number _____ - _____
City State Zip Code	D Type of Depositor Account (Check One) ☐ FDIC Insured Checking Account ☐ FDIC Insured Savings Account

E Account Information

You must enclose a personal voided check with your pre-printed name and address or deposit slip/letter from your financial institution indicating your account number, routing number, type of account (Checking or Savings).

PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the information and instructions on this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account. I authorize amounts transferred after my date of death or transmitted in error to be debited to my account.	**JOINT ACCOUNT HOLDER'S CERTIFICATION** I certify that I have read and understood the information and instructions on this form, including the **SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.** SIGNATURE OF JOINT ACCOUNT HOLDER DATE
SIGNATURE OF PAYEE DATE PHONE NUMBER: ( )	NAME AND ADDRESS OF JOINT ACCOUNT HOLDER

SECTION 2 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

Name and Address of Financial Institution	Bank Routing Number __ __ __ __ - __ __ __ __ __	
Branch Name and Number	Branch Telephone Number ( ) Branch Fax Number ( )	Account Owners/Signers (must include Payee name)

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and account owners. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above. I also confirm the account listed above is FDIC Insured.

Print or Type Representative's Name	Signature of Representative	Date