

Tel. 942-8690

RHODE ISLAND LABORERS' ANNUITY FUND
410 South Main Street
Suite 200
Providence, RI 02903

REQUEST FOR TERMINATION BENEFITS

Name of Participant _____ S.S.# _____

Address_ (Required) _____ Date of Birth _____

_____ Phone No. _____

Spouse's Name _____ Spouse's S.S.# _____

Employer: _____ Date of Last Employment _____

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Termination benefits are requested for the following reason (check one):

- () I have not been employed at the Laborers' trade within the territorial jurisdiction covered by the Collective Bargaining Agreement. Benefits are not payable for **6 full months** after the month I last worked at the trade.

Write dollar amount \$ _____ if blank, maximum allowable will be paid.

- () I have made application to the Rhode Island Laborers' Pension Fund and intend to retire effective _____.

- () I am totally and permanently disabled and **have included proof** of such disability with this application (social security award).

- () Qualified Domestic Relations Order (**QDRO**)

- () Death of participant. **INCLUDE COPY OF CERTIFIED DEATH CERTIFICATE** (spouse or beneficiary must sign on back of this page).

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- () IF YOU ARE NOT MARRIED, CHECK THIS BLOCK.

Note: Account balances under \$1,000 will be paid in a lump sum. If the account balance exceeds \$1,000.00 and the Joint-and-50% Survivor Option is not elected, your spouse must sign below on the back of this page and have this form notarized.

Payment Option: (CHECK ONE BLOCK ONLY)

- () Make check payable to me. 20% of distribution will be withheld for Federal income tax).

- () This is a direct rollover to an IRA or another qualified pension plan. No tax will be withheld. Make check payable to the following. **A TRANSFER FORM FROM THE BANK OR FINANCIAL INSTITUTION IS REQUIRED.**

FOR ROLLOVERS ONLY

Name of Bank or Financial Institution: _____

Address: _____

Acct No.: _____

Payment Option Continued:

() If a portion of account balance will be rolled over and the remainder will be made to the participant, indicate the amounts as follows: (Distributions paid to participant will be subject to 20% Federal Income Tax withholding)

Amount being rolled over: _____

Amount paid to participant: _____

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Options (CHECK ONE BLOCK ONLY):

() Lump Sum

() Period certain of 60 months. A monthly amount payable for 60 months.

() Joint-and-50% Survivor Annuity Pension. A monthly amount payable to the participant for his/her lifetime with 50% of that amount payable to his/her surviving spouse for his/her lifetime.

() Monthly Payments for withdrawals on or after January 1, 2020, a specific number of Monthly payments in an amount of at least \$100 per month, not to exceed 120 monthly payments. Participant may choose the number of monthly payments he/she will receive. The amount of monthly payments shall be adjusted annually based on the valuation of the Participant's Individual account at the end of the year.

Number of Monthly Payments Requested: _____

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*******SIGNATURES BELOW MUST BE NOTARIZED IF BALANCE EXCEEDS \$1000.00*******

I certify the information on this form is complete and true.

Date _____ Signature of Participant _____

Social Security No. (If not participant) _____

Notary Public: _____

I swear that I am the legal spouse of the above named participant. I hereby consent to my spouse's rejection of the Joint-and-50% Survivor Annuity Pension. I understand that as a result, I will not be paid a pension from the Annuity Plan after my spouse's death (unless death benefits are payable under another provision of the plan).

Date _____ Signature of Spouse _____

Notary Public: _____

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