



APPLICATION DATE _____

APPLICATION FOR RETIREMENT PENSION BENEFIT

PRINT OR TYPE ALL INFORMATION

PARTICIPANT SOCIAL SECURITY NO.	CODE 1	LAST NAME	FIRST	MI	SEX	IF FEMALE, MAIDEN NAME
ADDRESS			CITY		STATE	ZIP CODE
AREA CODE ()	PHONE NO. -	DATE OF BIRTH	MONTH	DAY	YEAR	DATE OF RETIREMENT
MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		SPOUSE'S LAST NAME	FIRST	M.I.	IF FEMALE, MAIDEN NAME	
SPOUSE'S SOCIAL SECURITY NO.		SPOUSE'S BIRTHDATE	MONTH	DAY	YEAR	

LIST CHILDREN'S COMPLETE INFORMATION				
NAME SOCIAL SECURITY NUMBER	ADDRESS (City, State, ZIP Code)	BIRTHDATE		
		MONTH	DAY	YEAR

PRESENT OR MOST RECENT TEAMSTER EMPLOYER	TEAMSTER LOCAL UNION NO.	MILITARY SERVICE	FROM	TO
--	--------------------------	------------------	------	----

LIST COVERAGE UNDER ANY OTHER TEAMSTER PENSION FUND AND/OR COMPANY PENSION FUND		PERIOD OF COVERAGE			
NAME OF FUND	CITY AND STATE	FROM		TO	
		MONTH	YEAR	MONTH	YEAR

PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTATION AS IT APPLIES:

- YOUR BIRTH CERTIFICATE (OR OTHER PROOF OF AGE)
 SPOUSE'S PROOF OF AGE
 MARRIAGE CERTIFICATE
 DIVORCE DECREE
 MILITARY DISCHARGE PAPERS (DD214)

PLEASE NOTE THAT THE EFFECTIVE DATE OF YOUR BENEFITS IS GENERALLY LIMITED TO NO MORE THAN 12 MONTHS FROM THE FUND'S RECEIPT OF NOTIFICATION OF YOUR RETIREMENT DATE.

Return to: Central States, Southeast and Southwest
 Area Pension Fund
 P. O. Box 5109
 Des Plaines, IL 60017-5109

EMPLOYMENT HISTORY

LIST ALL EMPLOYMENT BEGINNING WITH YOUR PRESENT OR MOST RECENT EMPLOYER.

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	PERIOD OF EMPLOYMENT FROM/TO DATES	LOCAL # AT TIME OF EMPLOYMENT	OFFICE USE ONLY:	
	ADDRESS			EFF. DATE	MEMBER EFF. DATE
	CITY, STATE & ZIP				
COMPANY PREVIOUSLY OR LATER KNOWN AS		COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TYPE OF WORK (BE SPECIFIC)					
REASON FOR LEAVING					
	ADDRESS				
	CITY, STATE & ZIP				
COMPANY PREVIOUSLY OR LATER KNOWN AS		COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TYPE OF WORK (BE SPECIFIC)					
REASON FOR LEAVING					
	ADDRESS				
	CITY, STATE & ZIP				
COMPANY PREVIOUSLY OR LATER KNOWN AS		COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TYPE OF WORK (BE SPECIFIC)					
REASON FOR LEAVING					
	ADDRESS				
	CITY, STATE & ZIP				
COMPANY PREVIOUSLY OR LATER KNOWN AS		COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TYPE OF WORK (BE SPECIFIC)					
REASON FOR LEAVING					
	ADDRESS				
	CITY, STATE & ZIP				
COMPANY PREVIOUSLY OR LATER KNOWN AS		COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TYPE OF WORK (BE SPECIFIC)					
REASON FOR LEAVING					

ADD ADDITIONAL PAGES FOR EMPLOYMENT HISTORY IF NEEDED

Have you ever worked in a supervisory capacity, been self-employed, worked as an owner-operator or had any ownership in a company?

Yes No If yes, complete the following:

COMPANY NAME	PERIOD OF EMPLOYMENT FROM/TO DATES	POSITION	DID YOU HAVE THE RIGHT TO HIRE, FIRE, OR RECOMMEND IT?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

For tax purposes, I certify that I am I am not a United States citizen.

OATH AND SIGNATURE

I am applying for a pension benefit from Central States, Southeast and Southwest Areas Pension Fund. Under penalty of perjury, I certify that the information I have given in this application is true and correct to the best of my knowledge.

APPLICANT SIGNATURE

DATE

EMPLOYMENT AFFIDAVIT

(FORM MUST BE COMPLETED IN FULL)

The information you provide on this form may assist us in granting additional credited service toward a possible future pension benefit. Please return to:

Central States Southeast and
Southwest Areas Pension Fund
Pension Group
Post Office Box 5109
Des Plaines IL 60017-5109

SOCIAL SECURITY NUMBER

_____ - _____ - _____

LAST NAME

FIRST NAME

M.I.

STREET ADDRESS

CITY

STATE

ZIP CODE

Company Name _____ Is company still in business? YES NO

Affiliated with or also known as: _____

Location (City, State) _____

Type of Industry/Product/etc. _____

Retail or Wholesale? _____

PERIOD OF EMPLOYMENT		CHECK ONE		Local Union	TYPE OF WORK (if more than one duty, please list them and specify the main duty)
From (month/day/year)	To (month/day/year)	Part-time or Casual	Full Time		

During each of the following calendar years, the above person was employed for at least 1,000 hours:

During each of the following calendar years, the above person was employed for at least 500 hours but less than 1,000 hours:

Indicate which of the above calendar years the above person worked under a collective bargaining agreement with the teamster union:

Did the person have supervisory authority and the power to hire and fire or recommend it? YES NO

If yes, please explain _____

I know these facts to be true from:

_____ my personal knowledge of the person and/or

_____ work records maintained by the above named company.

I HEREBY CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Name of Person
Signing Form _____
(Please Print)

Signature _____

Address _____

Phone Number _____

My relationship to the employee is:

_____ manager / supervisor of the above company

_____ co-worker

_____ other (please explain) _____

Date _____

RETIREMENT DECLARATION FORM

I am naming _____, _____ as my retirement date and wish to have my retirement benefits begin as of the first day of the following month.
(month, day) (year)

I certify that:

- I have not been working and I do not intend to become employed subsequent to my retirement date in any capacity (including self-employment) in the near future.

OR

- I have worked and/or I plan on working subsequent to my retirement date in the following capacity (including self-employment). Attach additional pages, if necessary:

Company Name: _____

Company Address: _____

Telephone Number: _____

Type of Industry: _____

Job Title: _____

Exact Job Duties (be specific): _____

Teamster Local Union, if any: _____

Start Date: _____ Termination Date: _____

Number of Hours Worked Per Month: _____

Still Working?: _____ Yes _____ No

I certify that the information I have given above is true and correct and I agree that I will promptly notify the Pension Fund if I return to work in any capacity (including self-employment) or if my employment noted above changes, so that the Fund can determine if the employment is prohibited.

Applicant's Signature: _____ Date: _____

Applicant's Name: _____ SSN: _____

(Please Print)

**JOINT AND 50% SURVIVING SPOUSE OPTION
ELECTION FORM**

I/We have read the summarized information on the Joint and 50% Surviving Spouse Option appearing on the back of this page and understand its financial effect on any benefits I/We may be entitled to receive from the Central States, Southeast and Southwest Areas Pension Fund.

Participant's Name: _____

Participant's Social Security Number: _____ Date of Birth _____

Spouse's Name (Including Maiden, if applicable): _____

Spouse's Social Security Number: _____ Date of Birth _____

- I/WE DO NOT WANT** the Joint and Survivor coverage and understand the financial effect (no lifetime surviving spouse benefit).

Note: Both the Participant and Spouse must sign this section of the Joint and Survivor Election Form in the presence of a Notary Public and each signature must be notarized. If either signature is missing, or if the form is not properly notarized, it will be returned for correction.

Participant's Signature Date

Spouse's Signature Date

Subscribed and sworn to before me:

Subscribed and sworn to before me:

Notary's Signature Date

Notary's Signature Date

- I/WE WANT** the Joint and Survivor Coverage. I understand that my pension benefit will be reduced to provide my surviving spouse with a lifetime benefit. After my death, my surviving spouse will receive a lifetime benefit equal to 50% of my monthly benefit.

Please attach copies of your spouse's birth certificate and your marriage certificate (if not already sent) and sign the form below.

Participant's Signature: _____

Spouse's Signature: _____

Date: _____

Important: This form should be returned to the Pension Fund no earlier than 1 year before the applicant's retirement date, and no later than 90 days after the benefit effective date.

Central States, Southeast and Southwest
Areas Pension Fund
P.O. Box 5109
Des Plaines, IL 60017-5109

JOINT AND 50% SURVIVING SPOUSE OPTION INFORMATION

WHY IS THIS INFORMATION IMPORTANT TO ME?

The Joint and Surviving Spouse Option (JSO) is a form of payment under which your surviving spouse will receive a lifetime monthly benefit from Central States after your death.

Central States is required by law to make JSO coverage available when calculating your retirement benefit. However, if both you and your spouse agree, you can elect not to take the JSO coverage. The period of time during which you and your spouse are eligible to make the decision on whether to take JSO coverage is called your "election period". **After the "election period" expires you cannot change your decision about how you want your benefit paid.** It is most important, therefore, to understand JSO coverage and its direct effect on you and your spouse. Because of the additional cost to the Fund for providing this lifetime benefit for your surviving spouse, your benefit is reduced as outlined below if you choose this option.

IF WE CHOOSE THIS OPTION, HOW MUCH WILL MY SPOUSE RECEIVE WHEN I DIE?

If you receive your benefit with the JSO coverage, after your death your spouse will receive 50% of your monthly benefit for life.

HOW MUCH WILL MY BENEFIT BE REDUCED TO PROVIDE FOR THIS OPTION?

Your benefit will be reduced based on the difference in age between you and your spouse as follows:

If you are older than your spouse:

<u>Age difference in years</u>	<u>Percentage of Benefit Payable</u>
0-10	85%
11	84%
12	83%
13	82%
14	81%
15	80%
16	79%
17	78%
18	77%
19	76%
20 or more	75%

If you are younger than your spouse:

<u>Age difference in years</u>	<u>Percentage of Benefit Payable</u>
0-10	85%
11	87%
12	89%
13	91%
14	93%
15 or more	95%

Example: John is age 60 and qualified for a \$1000 monthly pension. His wife Mary is age 55. If John elects JSO coverage, he would receive \$850 per month (\$1000 multiplied by .850). Upon John's death, Mary will receive \$425 per month for the rest of her life.

IF WE DECLINE THE JSO COVERAGE, ARE THERE ANY DEATH BENEFITS PAYABLE?

If you do not elect the JSO coverage and are receiving a retirement pension other than a Vested Pension or Contribution-Based Pension, the death benefit payable depends on your Benefit Class at the time you retire.

- If you retire under Benefit Class 1 through 3, a \$1000 death benefit is payable regardless of how long you have been receiving a pension benefit. Also, if your spouse dies first you would receive a \$500 death benefit.
- If you retire under Benefit Class 4 or higher and you die before receiving 60 months of benefits, your surviving spouse would receive a monthly benefit equal to your monthly benefit for the remainder of the first 60 months. There are no survivor benefits or death benefits payable after 60 months.

Without the JSO coverage there are no death benefits available to your surviving spouse if you die while receiving a Vested Pension or Contribution-Based Pension.

WHAT IS OUR "ELECTION PERIOD" TO DECIDE IF WE WANT THE JSO COVERAGE?

The election period starts 90 days prior to the date you retire and extends until the 90th day after the date you begin to receive payment of your retirement pension benefit. During the "election period" you can change your mind as often as you like. Just write the Central States Pension Fund at: P.O. Box 5109, Des Plaines, IL 60017-5109. If you decide to change your election to decline the JSO coverage, both you and your spouse must sign the statement and both signatures must be notarized.

WHAT HAPPENS IF MY SPOUSE DIES FIRST?

If you choose this option and your spouse (or divorced spouse) dies before you, your reduced monthly benefit can generally be restored to the amount you would have received if you had not taken the JSO. Send us a copy of the death certificate of your spouse and include a letter telling us that you wish to have your reduced monthly benefit increased under the "restoration" feature. Please include your Social Security Number on the letter.

WHAT IF I TAKE THE JSO AND WE GET DIVORCED?

Once your "election period" is over you cannot change back to a full benefit even if you get divorced. You would continue to receive a reduced JSO benefit. However, should your divorced spouse die before you, you would generally be eligible for a benefit increase under the "restoration" feature.

WHAT IF I GET DIVORCED AND MARRY AGAIN?

JSO coverage is only applicable to the spouse to whom you are legally married at the time your JSO benefits begin. A JSO benefit is not payable to a spouse whom you marry after you retire.

IF MY SPOUSE REMARRIED AFTER MY DEATH, DOES THE BENEFIT HE OR SHE RECEIVES AS A RESULT OF THE JSO COVERAGE STOP?

NO, your spouse would receive the benefit for life.

TAX WITHHOLDING

SECTION ONE

I certify under penalties of perjury that I am a United States citizen, and I elect tax withholding as follows:

1. I elect not to have income tax withheld from my pension.
2. I want the following amount in taxes withheld from each of my pension checks: \$ _____ (no pennies)
3. I want my withholding from each monthly pension check to be figured using the number of allowances and marital status shown.

Marital status: Single Married Number of allowances:

Signature: _____ Date: _____

Social Security Number: _____

SECTION TWO

I certify under penalties of perjury that I am *not* a United States citizen, nor a resident alien nor an expatriate to avoid U.S. taxes, and elect tax withholding from my pension checks as follows:

1. I elect withholding per the tax tables as allowed by law
2. I elect withholding per the treaty rate for the country of which I am a citizen:

(If Form 1001 is required, the Fund will send one to you for your completion.)

Signature: _____ Date: _____

Social Security Number: _____

**Central States Pension Fund
PO Box 5113
Des Plaines, IL 60017-5113**

BENEFIT PAYMENT METHOD

You can avoid worrying about when you will receive your pension check by using the Fund's Electronic Fund Transfer (EFT) program. Under the EFT program your pension check is deposited electronically and automatically into your checking or savings account on the first day of each month (unless the first day of the month falls on a weekend or a banking holiday). If you are eligible for retirement benefits, your first one or two pension checks will be mailed to your home address and subsequent payments will be deposited electronically into your checking or savings account.

I hereby authorize the Central States, Southeast and Southwest Areas Pension Fund, and the financial institution shown below, to deposit my pension benefit directly into my account each month. If funds to which I am not entitled are deposited into my account, I authorize the Fund to direct the bank to return those funds. This authorization will remain in effect until I file a new authorization form or cancel my participation. I understand that I must keep the Fund informed of any change in my home address even if I use this electronic direct deposit program.

Signature: _____ Date: _____

Social Security Number: _____ Home telephone number: (_____) _____

Home address: _____

City: _____ State: _____ Zipcode: _____

Bank name: _____

Bank address: _____

City: _____ State: _____ Zipcode: _____

Type of account: Checking ____ Savings ____

IMPORTANT: In the space below attach a voided check or deposit slip with the correct bank routing and transit numbers.

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

I do not want electronic fund transfer and I elect instead to have my benefit check mailed to my home address each month. Although the Fund makes every effort to deliver my checks by the first of the month, I understand that my check may be delayed for reasons beyond the Fund's control and cannot guarantee delivery of my checks by the first day of each month. I understand that in the event a check is lost the Fund cannot issue a replacement check until the 10th business day of the month.

Signature: _____ Date: _____

Social Security Number: _____

Approximately 30 days before your retirement date, mail this form to:

**Central States Pension Fund
PO Box 5113
Des Plaines, IL 60017-5113**

IMPORTANT: You must keep the Fund informed of any change in your address, *regardless* of which payment method you choose.