CENTRAL STATES PENSION FUND

APPLICATION FOR DISABILITY BENEFIT

Dear Participant:

This Application for Disability Benefit packet must be completed and forwarded to the address shown below before you can be approved for a disability benefit from the Pension Fund.

Remember, it is important to forward all appropriate documents (such as proof of age, marriage certificate, Social Insurance Award, etc.) to our office. Failure to do so may delay the processing of your application.

Please note per Section 4.13 of the Pension Plan:

> *"The Pension Fund shall permanently suspend all Periodic Benefit Payments of a Disabled Participant during periods of their Reemployment."*

All forms and documents should be submitted to the following address:

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

If you have any questions, please call us toll-free at 1-800-323-5000
Or visit our website at: www.MyCentralStatesPension.org

DISABILITY BENEFIT APPLICATION FORM/
BACKGROUND INFORMATION/EMPLOYMENT HISTORY

This application must be fully answered by the claimant or, if the claimant is mentally or physically incompetent, their appointed guardian or conservator or anyone legally empowered to do so.

PRINT OR TYPE ALL INFORMATION

PARTICIPANT'S SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	MIDDLE INITIAL	GENDER ☐ MALE ☐ FEMALE	IF FEMALE, MAIDEN NAME

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER (incl. Area Code)

E-MAIL ADDRESS

MILITARY SERVICE (MONTH / YEAR) FROM TO	DATE OF BIRTH MONTH / DAY / YEAR	DISABILITY DATE MONTH / DAY / YEAR

IS THIS DISABILITY THE RESULT OF (CHECK ONE) ILLNESS ☐ INJURY ☐ JOB-RELATED INJURY ☐ DATE OF INJURY	ARE YOU RECEIVING BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION? ☐ YES IF YES, ATTACH A COPY OF THE ENTIRE AWARD ☐ NO IF NO, DATE APPLIED FOR:

MARITAL STATUS MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐	SPOUSE'S LAST NAME	FIRST NAME	MIDDLE INITIAL	IF FEMALE, MAIDEN NAME

SPOUSE'S SOCIAL SECURITY NO.	SPOUSE'S DATE OF BIRTH MONTH / DAY / YEAR	DATE OF MARRIAGE MONTH / DAY / YEAR

LIST CHILDREN'S COMPLETE INFORMATION

NAME	ADDRESS (City, State, ZIP Code)	BIRTHDAY MONTH / DAY / YEAR	RELATIONSHIP

LIST COVERAGE UNDER ANY OTHER TEAMSTER PENSION FUND AND/OR COMPANY PENSION PLAN

NAME OF FUND / COMPANY PLAN	CITY AND STATE	PERIOD OF COVERAGE FROM / TO DATES (MONTH / YEAR)

PLEASE INCLUDE THE FOLLOWING DOCUMENTATION WITH THIS APPLICATION AND MAIL IT TO THE ADDRESS SHOWN ON PAGE 4:

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

LIST **ALL EMPLOYMENT**, REGARDLESS OF WHETHER IT PROVIDED FOR PARTICIPATION IN CENTRAL STATES PENSION FUND, BEGINNING WITH YOUR PRESENT OR MOST RECENT EMPLOYER. ADD ADDITIONAL PAGES FOR EMPLOYMENT HISTORY IF NEEDED.

NAME OF EMPLOYER	**ADDRESS OF EMPLOYER**		**PERIOD OF EMPLOYMENT FROM / TO**	**LOCAL UNION # AT TIME OF EMPLOYMENT**
EMPLOYER	ADDRESS		FROM/TO (MONTH/YEAR)	LOCAL UNION #
	CITY, STATE & ZIP			
TYPE OF WORK (BE SPECIFIC)				
REASON FOR LEAVING			COMPANY OUT OF BUSINESS? ☐ YES ☐ NO	
WORK COVERED BY TEAMSTER CONTRACT REQUIRING CONTRIBUTIONS TO CENTRAL STATES PENSION FUND?			☐ YES ☐ NO	

EMPLOYER	ADDRESS		FROM/TO (MONTH/YEAR)	LOCAL UNION #
	CITY, STATE & ZIP			
TYPE OF WORK (BE SPECIFIC)				
REASON FOR LEAVING			COMPANY OUT OF BUSINESS? ☐ YES ☐ NO	
WORK COVERED BY TEAMSTER CONTRACT REQUIRING CONTRIBUTIONS TO CENTRAL STATES PENSION FUND?			☐ YES ☐ NO	

EMPLOYER	ADDRESS		FROM/TO (MONTH/YEAR)	LOCAL UNION #
	CITY, STATE & ZIP			
TYPE OF WORK (BE SPECIFIC)				
REASON FOR LEAVING			COMPANY OUT OF BUSINESS? ☐ YES ☐ NO	
WORK COVERED BY TEAMSTER CONTRACT REQUIRING CONTRIBUTIONS TO CENTRAL STATES PENSION FUND?			☐ YES ☐ NO	

EMPLOYER	ADDRESS		FROM/TO (MONTH/YEAR)	LOCAL UNION #
	CITY, STATE & ZIP			
TYPE OF WORK (BE SPECIFIC)				
REASON FOR LEAVING			COMPANY OUT OF BUSINESS? ☐ YES ☐ NO	
WORK COVERED BY TEAMSTER CONTRACT REQUIRING CONTRIBUTIONS TO CENTRAL STATES PENSION FUND?			☐ YES ☐ NO	

HAVE YOU EVER WORKED IN ANY OF THE FOLLOWING CAPACITIES WHILE A PARTICIPANT OF CENTRAL STATES PENSION FUND?
☐ Manager/Supervisor ☐ Self-employment ☐ Owner/Operator OR ☐ Had significant ownership (50% or more) in the company?
If yes, complete the following:

COMPANY NAME	PERIOD OF EMPLOYMENT FROM / TO (MONTH / YEAR)	SITUATION (SEE ABOVE)	DID YOU HAVE THE RIGHT TO HIRE, FIRE, OR RECOMMEND IT? (CHECK ONE)	
			☐ YES	☐ NO
			☐ YES	☐ NO

ANSWER THE FOLLOWING QUESTIONS FULLY:

TO WHAT EXTENT ARE YOU ABLE TO WORK?

ON WHAT DATE WAS IT NECESSARY TO GIVE UP ALL DUTIES?	MONTH	DAY	YEAR

HAVE YOU DONE ANY TYPE OF WORK SINCE YOUR DISABILITY? ☐ YES ☐ NO
If yes, please include employment information below:

EMPLOYER	ADDRESS		FROM/TO (MONTH/YEAR)	LOCAL UNION #
	CITY, STATE & ZIP			
TYPE OF WORK (BE SPECIFIC)				
WORK COVERED BY TEAMSTER CONTRACT REQUIRING CONTRIBUTIONS TO CENTRAL STATES PENSION FUND? ☐ YES ☐ NO				

EMPLOYER	ADDRESS		FROM/TO (MONTH/YEAR)	LOCAL UNION #
	CITY, STATE & ZIP			
TYPE OF WORK (BE SPECIFIC)				
WORK COVERED BY TEAMSTER CONTRACT REQUIRING CONTRIBUTIONS TO CENTRAL STATES PENSION FUND? ☐ YES ☐ NO				

OATH AND SIGNATURE

I am applying for a disability 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. I agree to notify the Fund immediately of **any** employment.

APPLICANT'S SIGNATURE **DATE**

IMPORTANT INFORMATION REGARDING YOUR BENEFITS AND THE PENSION PROTECTION ACT

On March 24, 2008, the Pension Fund's actuary certified that the Pension Fund is in critical status under the Pension Protection Act (PPA), and notice of this fact was given to all participants on April 8, 2008. With respect to plans in critical status, the PPA creates a category of "adjustable benefits," which generally includes all benefits other than a contribution based pension payable at age 65; these benefits may be eliminated or reduced in the future (even for participants that have retired and already begun receiving their pensions), largely depending on whether the participant's employer (or former employer) continues to participate in the Pension Fund and agrees to a contribution schedule sufficient to maintain current benefits. Although the Pension Fund anticipates that the vast majority of bargaining units will elect a contribution schedule that keeps current benefits in place, because of the possibility of a reduction or elimination in benefits, you should weigh your decision to retire with care. In addition, under the PPA, the Pension Fund cannot guarantee that it will never be required to change its existing rules concerning adjustable benefits. However, in the event your adjustable benefits are reduced or eliminated in the future, you will receive a separate notice at least 30 days prior to the effect of any such benefit reduction.

RETURN TO: CENTRAL STATES, SOUTHEAST AND SOUTHWEST
AREAS PENSION FUND
P.O. BOX 5109
DES PLAINES, IL 60017-5109

TAX WITHHOLDING FORM

Note: Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You also may use Form W-4P to choose **(a)** not to have any income tax withheld from the payment (except for eligible rollover distributions, or payments to U.S. citizens delivered outside the United States or its possessions) or **(b)** to have an additional amount of tax withheld.

You may use the Pension Benefit Tax Withholding calculator on our website at www.MyCentralStatesPension.org to assist you in determining your tax withholding. If you have any questions, please consult your tax professional, or obtain a complete Form W-4P from the IRS for additional worksheets and instructions.

If you wish to make a tax election, please complete Form W-4P below.

Form **W-4P** Department of the Treasury Internal Revenue Service	**Withholding Certificate for Pension or Annuity Payments**	OMB No. 1545-0415
Type or print your full name		Your social security number
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract **N/A**
City or town, state, and ZIP code		

Complete the following applicable lines:

1 Check here if you do not want any federal income tax withheld from your pension or annuity. (Do not complete lines 2 or 3.) . . ➤ ☐

2 Total number of allowances and marital status you are claiming for withholding from each periodic pension or annuity payment. (You may also designate an additional dollar amount on line 3.) . . . . . ➤ _____ (Enter number of allowances)

Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher "Single" rate

3 Additional amount, if any, you want withheld from each pension or annuity payment. (Note. *For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.)* . . . . . ➤ $_____ (No pennies)

Your Signature ➤ Date ➤

If you are a nonresident alien and do not have a Social Security Number you may not use Form W-4P. Please write us at Central States Pension Fund, PO Box 5113, Des Plaines, IL 60017-5113 if this applies to you.

INSTRUCTIONS FOR COMPLETING FORM W-4P

TO ELECT NOT TO HAVE FEDERAL TAXES WITHHELD FROM YOUR PENSION BENEFIT:

1. PRINT YOUR NAME, ADDRESS AND SOCIAL SECURITY NUMBER IN THE SPACE PROVIDED.

2. CHECK THE BOX IN LINE 1.

3. SIGN AND DATE THE ELECTION AND RETURN TO CENTRAL STATES.

TO ELECT TO HAVE FEDERAL TAXES WITHHELD FROM YOUR PENSION BENEFIT (BASED ON IRS TAX TABLES):

1. PRINT YOUR NAME, ADDRESS AND SOCIAL SECURITY NUMBER IN THE SPACE PROVIDED.

2. CHECK ONE OF THE MARITAL STATUS OPTIONS AND COMPLETE THE NUMBER OF ALLOWANCES SECTION IN LINE 2.

3. YOU CAN DESIGNATE TO HAVE AN AMOUNT WITHHELD, IN ADDITION TO THE TAX TABLE AMOUNT, ON LINE 3.

4. SIGN AND DATE THE ELECTION AND RETURN TO CENTRAL STATES.

***Please note that the IRS does not allow for a specific ("flat") amount to be withheld.** Therefore, tax withholding must be based on your marital status and number of allowances plus any additional amounts you wish to have withheld. If you need additional assistance or have any questions regarding Form W-4P, please consult your tax professional or see IRS Form W-4P for complete withholding instructions on pensions.

------This Form Is Required To Initiate Your Pension Benefit Payments------

BENEFIT PAYMENT METHOD FORM

You can avoid worrying about when you will receive your pension check by using the Fund's Electronic Funds 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 SENT TO YOUR MAILING 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/we authorize the Fund to direct the bank to return those funds and to provide any and all information in their records which may assist the Fund in the recovery of those funds including but not limited to the identity of all account holders. This authorization will remain in effect until I file a new authorization form or cancel my participation.

Signature: _____ Date: _____

Social Security Number: _____ Home Telephone Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Bank Name: _____

Bank Address: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ Checking ☐ Savings

Routing Number: _____ * Account Number: _____

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

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

***9 DIGIT CODE IN THE LOWER LEFT CORNER OF CHECK OR DEPOSIT SLIP THAT STARTS WITH 0, 1, 2 OR 3

☐ I do not want electronic funds transfer and elect instead to have my benefit check sent to my mailing address each month. I understand that my benefit checks will be mailed on the first day of each month and that my check may be delayed for reasons beyond the Fund's control and that there is no guaranteed delivery date. I further 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: _____

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