

Lake County, Illinois Plasterers & Cement Masons Retirement Savings Plan

915 National Parkway, Suite F, Schaumburg, IL 60173

Toll Free (800) 249-7947, Fax (847) 519-1979

**Application
Retirement Withdrawals**

Dear Participant:

Enclosed is an application packet for a Retirement distribution from the Lake County, Illinois Plasterers & Cement Masons Retirement Savings Plan. Please make sure to review the documents in this packet carefully. **Once your application is complete for a partial withdrawal, a \$15 nonrefundable fee will be deducted from your account balance. There is no fee for a total lump sum withdrawal.** Upon completion, return the application packet and all necessary supporting documents to the Fund Office for processing. Your application will be reviewed and you will be notified in writing as to whether or not any additional information is necessary to process your distribution. It will take approximately 30 to 45 days to process this application.

Please be advised that your investment account will be subject to market variances up to the date of the actual disbursement. You may want to review your investment choice to take into consideration current economic conditions.

Please contact the Fund Office if you have any questions.

Sincerely,

Fund Office

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Please read this notice carefully. It contains important information regarding your application for a distribution from the Lake County, Illinois Plasterers and Cement Masons Retirement Savings Plan.

All Forms are required to be completed and returned.

Proof of Age. You must provide proof of your age when you apply for a distribution. A copy of your birth certificate is the best document for proof of age. If you do not have your birth certificate, you may submit a baptismal certificate or statement as to the date of birth from a church record, notification of registration of birth in a public registry of vital statistics, certification of record of age by the U.S. Census Bureau, a hospital birth record, or a valid passport. If you cannot provide any one of the above records please contact the Fund Office.

Social Security Number. You must submit a copy of your Social Security card. You may call your local office of the Social Security Administrative Office for information if you do not have one.

Notarization. Some sections of the application require your election or your spouse's consent. These sections need to be witnessed by a Plan Representative or Notary Public.

Foreign Documents. Please note that all foreign documents should be accompanied by a notarized English translation.

For further information on these and other pension issues please refer to your Summary Plan Description booklet. If you have additional questions please call the Fund Office at (888) 703-8872. If there is any conflict between this Application and Notice To Participants in the legal documents, the documents will rule.

Check Off List:

- Copy of Birth Certificate for Participant
- Copy of Marriage Certificate
- Copy of any prior Divorce Decrees and Property Settlements, or Death Certificates of prior spouses
- Copy of Social Security Card
- If Married, the Spousal Waiver must be signed by your spouse and witnessed by a Plan Representative or a Notary Public
- All Foreign Documents must have a notarized English translation.
- The Distribution Election form must be completed and signed.

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PARTICIPANT INFORMATION:

Name: _____ S.S. No: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Telephone Number: () _____

Cell Phone Number: () _____

Local Union No. _____ Date Last Worked in Trade: _____

Spouse's Name: _____ Spouse's S.S. No.: _____

Spouse's Date of Birth: _____

REASON FOR RETIREMENT: *(Please Check One)*

Retirement Effective Date: _____

Date Last Worked: _____

Disability Date of Disability: _____

Attach copy of medical report or Social Security Disability award

Termination Date Last Worked: _____

AMOUNT OF DISTRIBUTION: *(Please Check One)*

Total Distribution of Individual Account

Percentage of Individual Account Balance: _____ %

Specific Dollar Amount of Individual Account Balance: \$ _____

Series of partial lump sum distributions which may be made each year for a period of up to 10 calendar years. Number of years: _____

Participant's Signature: _____ Date: _____

Affidavit of Marital Status

MARITAL STATUS: Please Check One That Applies:

- I have never been married
- I am currently married (attach a copy of your marriage certificate)
- I am divorced (attach a copy of the divorce decree and property settlement)

Are you in the process of a divorce? *Check one:* yes no

- I am a widow/widower (attach a copy of the spouse's death certificate)
- I am remarried (attach a copy of the divorce decree and property settlement or copy of the spouse's death certificate)

You and, if you are married, your spouse must sign this waiver if you both agree benefits are to be paid in a form other than a qualified joint and survivor form of benefit. A "qualified joint and survivor" benefit means, for married persons, a joint and survivor annuity which would provide monthly payments over the participant's lifetime and, one-half of the monthly payment amount to the participant's surviving spouse upon the participant's death for the rest of the surviving spouse's life and, for single persons, a single life annuity which would provide monthly payments to the participant for life.

I understand that I may revoke this election before the payment of the requested distribution.

Participant's Signature

Date

Spousal Waiver

I, the undersigned spouse of the above named participant of the Lake County, Illinois Plasterers & Cement Masons Retirement Savings Plan hereby consent to the above waiver of the qualified joint and survivor form of benefit and acknowledge that the effect of my consent to the waiver eliminates any right I would otherwise have to receive a portion of these benefits upon my spouse's death in the form of a qualified joint and survivor annuity. To the extent that my spouse accrues further benefits under the Fund after this date or dies prior to the complete distribution of his benefits held in the Fund, I understand that I have the right to receive any such amounts as a death benefit from the Fund to the extent that I may be my spouse's beneficiary. I understand that this waiver, once given, may not be revoked. I hereby swear, under oath, I am the spouse of the above participant.

Signature of Spouse

Print Name

Sworn and subscribed before me by _____
(Spouse's Name)

the above named Participant's Spouse, this _____ day of _____ 20 _____.
(day) (month) (year)

Notary Public or Fund Representative _____ (Seal)

Distribution Election Form

Attention: Before completing this form you should read the special tax notice regarding Plan payments. You also may wish to consult your tax advisor before making this election. Complete this section only if you will receive a pay-out in a lump sum, or other eligible rollover distribution.

If you will receive part or all of your benefits as an "eligible rollover distribution", you may elect to have part or all of that distribution transferred directly to an Individual Retirement Account (IRA) or to another qualified retirement plan (if it accepts rollovers). If you choose not to have an eligible rollover distribution transferred directly to an IRA or other retirement plan, the Plan is required to withhold 20 percent of the payment for federal income taxes. This withholding does not increase your taxes, but will be credited against any income tax you owe. (For further information on direct rollovers and withholding, please read the Special Notice Regarding Plan Payment that the Plan has given you).

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

- I do not want to roll over any of my payment to an IRA or other qualified retirement plan. Pay me the full amount of my benefits, after withholding 20 percent for federal income taxes as required by law.
- I want to roll over my payment directly to an IRA or other qualified retirement plan that accepts rollovers. The IRA or other retirement plan is named below.
- I would like to have only part of my payment directly rolled over. Please roll over \$ _____ to the IRA or qualified retirement plan named below and pay the remainder of my benefit to me, after withholding 20 percent for federal income taxes as required by law.

If you elected a direct rollover, you must provide all of the following information. Until you provide this information, no direct rollover can be made.

Please make payment of my benefits on my behalf to:

Name of IRA Trustee or Qualified Retirement Plan: _____

Address: _____
Street or P. O. Box *City* *State* *Zip*

Account Number: _____

Certification

If you have elected a direct rollover of all or part of your benefit, please read and sign the following statement:

I certify that the recipient of a direct rollover that I have named above is an Individual Retirement Account (not a Roth IRA), an Individual Retirement Annuity, or a qualified retirement plan that accepts rollovers. I understand that payment of my benefits to the Trustee of the IRA or qualified Plan will release the Trustees of the Lake County, Illinois Plasterers and Cement Masons Retirement Savings Plan from any further obligations or responsibilities with respect to the benefits so paid.

Participant's Signature

Date

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MEDICAL REPORT FOR A DISABILITY DISTRIBUTION: Complete only if you are applying for a distribution based on a Disability.

Patient Name: _____ Social Security No: _____

Address: _____

- A. I examined the patient on (date) _____ at (location) _____
- B. The nature of the disability is _____
- C. The disability commenced on or about (date) _____
- D. I consider the probable future duration of the disability to be _____
- E. Based on my examination and conversation with the patient, it is my opinion that the disability:
(Check the appropriate boxes")

Was or Was not contracted, suffered or incurred while the employee was engaged in a criminal enterprise.

Was or Was not as a result of chronic alcoholism, addiction to narcotics, or any substance abuse.

Was or Was not self-inflicted.

CERTIFICATION OF DISABILITY

Under the Pension Plan, "Permanent and Total Disability" means in part, total incapacity because of physical or mental condition so as to be prevented thereby from performing any duties in the Craft or Trade. I hereby certify that: (Please check one and complete as appropriate).

I am of the opinion this applicant is Permanently & Totally disabled.

I am of the opinion this applicant can engage in employment as follows: _____

Physician's Signature _____

Physician's Name: _____

Telephone (please print): _____

Address: _____