

The National Elevator Industry Pension Plan

Please follow the instructions listed below:

1. Read the “Procedures for Starting Your Pension Benefit booklet” found on the Plans website.
2. Print out the Pension Application only. You do not need to print the Procedures booklet.
3. To run a pension calculation, go to the NEI website **Member Portal** link at: <https://memberportal.neibenefits.org/nei/main/#!/account/login>
4. Sign in if you already have an account. If you do not have an account, select “**Create Account**” and follow the system prompts.
5. Once logged into the Member Portal, go to the **Pension Projections** screen. Enter the appropriate Retirement Date and click on “**Calculate**” to view your estimate calculation options.
6. Review your pension calculation carefully. Please note that the pension calculation will not take into account any Qualified Domestic Relation Orders (“QDRO”) or disability that you may have.
7. You may complete and return the pension application with appropriate documents to pension@neibenefits.org or via US mail to the Benefits Office. Please note that communications via email over the internet are not secure. Although unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.
8. Return the original of page 11 of your pension application if notarization is required.
9. Upon receipt, the Benefits Office will review your application for completeness and send you a confirmation with an updated pension calculation via US mail.
10. Note that your pension application can become effective no earlier than the first of the month following receipt of your pension application.
11. Pension type and benefit election may not be changed after you retire.
12. Once you decline health coverage it may not be reinstated at a later date.

THIS APPLICATION MUST BE RECEIVED IN THE FUND OFFICE NO LATER THAN 180 DAYS FROM DATE PRINTED OR THE APPLICATION IS VOID.

Date Received _____
(For Fund Office Use Only)

THE NATIONAL ELEVATOR INDUSTRY PENSION PLAN

19 Campus Blvd., Suite 200
Newtown Square, PA 19073-3288
Phone: (800)523-4702

PENSION APPLICATION

(PLEASE RETURN ALL PAGES OF THE APPLICATION OR THE APPLICATION WILL BE VOID)

PART I - GENERAL INFORMATION

1. Name (Last, First, Middle) _____

2. Address _____
Number and Street

_____ City State Zip Code

3. Telephone Number: () _____ Cell Number: () _____

4. Email Address: _____

5. Social Security Number (last 4 digits only): xxx-xx- _____

6. Local Union Number: _____

7. Date of Birth: _____

8. Date You Retired or Plan to Retire: _____ (Your pension can become effective no earlier than the first of the month following the receipt of your application in the Benefits Office.)

9. Did you serve in the Armed Forces of the United States after you began your employment in the Elevator Industry?

_____yes

_____no

If yes, from _____ (Mo./Yr.) to _____ (Mo./Yr.)

(Enclose copy of Military Discharge and Service Record - copy of Form DD214).

10. Were you ever out of work in the Elevator Industry due to Sickness or Accident? _____yes_____no

If yes, from _____ (Mo./Yr.) to _____ (Mo./Yr.) (Attach additional page if necessary.)

11. Are you now receiving or have you received after July 1, 1953 Weekly Income Benefits under the National Elevator Industry Health Benefit Plan? ___yes___no

If yes, from _____ (Mo./Yr.) to _____ (Mo./Yr.)

12. Are you now receiving or have you received after July 1, 1953 Workers' Compensation benefits from any State or the Federal Government? _____yes___no

If yes, from _____ (Mo./Yr.) to _____ (Mo./Yr.)

13. (a) Date first worked with the tools in Elevator Industry _____

(b) Date last worked with the tools in Elevator Industry _____

14. Reason for leaving the Elevator Industry: LAID-OFF DISABLED RETIRED OTHER (circle one)
(If other, please state reason) _____

15. Type of Pension for which your are applying (Please check one):

- Normal** Retirement Pension (Age 65 or greater)
- Early** Immediate Retirement Pension (Between Ages 55 and 65)
- Deferred:** Requested Effective Date _____
(You may be required to file a new application within 180 days of your planned Effective Date in order to fulfill the requirements of Federal Law. The Benefits Office will notify you if a new application is required.)
- Disability** Pension (Complete Item 16)
- Vested** Pension (Left the trade prior to age 55)

16. If you are applying for a Disability Pension, complete the following:

- (a) Nature of your disability _____
- (b) Date you last actually worked with the tools in the Elevator Industry _____
- (c) Have you applied for Social Security Disability Benefits? YES or NO (circle one)
if yes, date applied _____
and what is the status? APPROVED REJECTED PENDING (circle one)

If approved, enter the Effective Date payments were or will be made: _____
Month Day Year

If you have received a Notice of eligibility for Social Security Disability Benefits, please send a complete copy with this application; otherwise, mail a copy of the Notice to the Benefits Office when received. **DO NOT DELAY MAILING THIS APPLICATION. MAIL IT WHEN COMPLETED.**

Furthermore, regardless of the type of pension you are applying for, you cannot receive Weekly Indemnity (Short Term Disability) payments within in the same month as a pension payment.

17a. Starting with your most recent employment, list the names and addresses of all employers for whom you worked in the Elevator Industry. **Complete to the best of your knowledge.** (Attach additional sheets if you need more space.)

<u>Name of Employer</u>	<u>From Mo./Yr.</u>	<u>To Mo./Yr.</u>

17b. If you have at any time been employed by a general contractor as a Temporary Car Operator, please list such employment below starting with your most recent employment.

Name of Employer	Address	From Mo./Yr.	To Mo./Yr.
_____	_____	_____	_____
_____	_____	_____	_____

18. Did you ever work as a management/salaried employee in the Elevator Industry?
YES or NO (circle one). If yes, list company and dates.

Company Name	Address
_____	_____
From _____ to _____	

19. Did you ever work in the Elevator Industry for a company that did not participate in the NEI Benefit Plans (“non-contributory”), including an institution of higher learning? YES or NO (circle one)
If yes, list company and dates.

Company Name	Address
_____	_____
From _____ to _____	

20. Are you currently or have you ever worked as an Elevator Inspector? YES or NO (circle one)

Company Name	Address
_____	_____
From _____ to _____	

21. Do you intend to terminate your employment in the Elevator Industry? YES or NO (circle one)
If yes, termination date _____
(Must be prior to retirement date)

In order to receive a pension from the Plan you must withdraw completely from any further employment in work of the type covered by the trade or craft jurisdiction of the Union except as otherwise provided by the Plan. If you return to such employment after retirement, you must notify the Benefits Office in writing within 30 days. Under such employment, your pension benefits will be suspended and you risk permanent loss of health coverage, if you are eligible and elect such coverage as a retiree.

If you receive a Disability Pension from the Plan you may not engage in any regular gainful occupation or employment for compensation or profit except such employment which is found by the Trustees to be for the purpose of rehabilitation and not incompatible with the definition of Total and Permanent Disability. Also, you must inform the Plan if you lose entitlement to Social Security Disability benefits.

APPLICANT’S SIGNATURE _____ DATE _____

THE NATIONAL ELEVATOR INDUSTRY PENSION PLAN

PENSIONER'S FEDERAL INCOME TAX WITHHOLDING ELECTION UNDER
TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)

IMPORTANT: THIS PAGE MUST BE COMPLETED

SECTION 1
SELECTION OF TAX ELECTION

CHECK
ONE
ONLY

- A. I elect to have no Federal Income Tax withheld from my monthly benefit.
- B. I elect to have the following amount withheld from my monthly benefit \$ _____
- C. I elect to have Federal Income Tax withheld from my monthly benefit using _____ allowances or exemptions. My marital status is as checked below. enter number

SECTION 2
MARITAL STATUS

CHECK
ONE
ONLY

- Single
- Married
(If you wish withholding at a higher rate, complete SECTION 3)

SECTION 3
OPTIONAL ADDITIONAL WITHHOLDING ELECTION
(Do not complete if "A" or "B" under SECTION 1 is checked)

- I elect to have the following amount withheld from each monthly benefit, in *addition* to what will be withheld under "C" of SECTION 1 above.

INSERT AMOUNT \$ _____

STATE TAXES WILL NOT BE DEDUCTED

Date Signed

Signature of Pensioner

*Note: If you fail to complete this form, Federal Income Tax will be withheld as if you were married claiming three allowances as provided by the Act. If you do not elect to have enough tax withheld you may be responsible for payment of estimated tax and may incur tax penalties.

Your election will remain in effect until you revoke it. Any revocation will be effective no later than Jan. 1, May 1, July 1, or Oct. 1 after it is received, if received at least 30 days prior to the stated dates.

THE NATIONAL ELEVATOR INDUSTRY PENSION PLAN

**PART A
LIFE INSURANCE CONVERSION PRIVILEGE**

Since the \$40,000 Group Life insurance terminates at retirement (except for Disability retirees under age 65) you may convert all or any part of your \$40,000.00 Group Life Insurance with no medical examination or other evidence of insurability to an individual, self policy:

1. By applying to Amalgamated Life within 31 days after such termination of Insurance.
2. In any amount up to the amount for which you were insured under the Group Life Policy of the HEALTH BENEFIT PLAN as an active employee/participant.
3. To any individual life insurance policy then customarily issued by Amalgamated Life except Term Insurance.

Check box if you wish an application. (Cost of coverage supplied on application)

**PART B
BASIC HEALTH BENEFITS FOR PARTICIPANTS
AND ELIGIBLE DEPENDENTS PROVIDED BY HEALTH BENEFIT PLAN
(also see Part D)**

IMPORTANT: The applicant is reminded that Health benefits are available only to those members who have had coverage under the Health Benefit Plan immediately prior to retirement. Disability Retirees should complete only Part "C" and, if elected, Part "D". The cost of the insurance coverage elected is subject to change at the discretion of the Trustees, at any time. **IF THE COVERAGE IS REJECTED, IT CANNOT BE REINSTATED.**

Basic Health Benefits (that is, all benefits except Life Insurance, Weekly Indemnity Insurance, Dental and Vision Coverage) are extended to you, your spouse and eligible children, provided you authorize a monthly deduction from your pension. See Part D for Dental and Vision coverage. These benefits will be modified when you and/or your spouse becomes Medicare eligible. **You must elect Medicare Parts A & B when eligible.** In this regard, see your Health Benefit Plan Summary under "Co-ordination with Medicare." You must elect the Health Insurance coverage for yourself in order for your spouse to qualify for such coverage. Divorce terminates coverage for your spouse, though your spouse may be offered a temporary extension of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

CHECK
ONE
ONLY

- YES**, deduct from my pension the cost of health benefit coverage under the National Elevator Industry Health Benefit Plan. I make this authorization voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly benefit, or any portion thereof, to the National Elevator Industry Health Benefit Plan. I understand that the National Elevator Industry Health Benefit Plan has no enforceable right against the National Elevator Industry Pension Plan or to any part of my pension benefit.

Provide names and dates of birth of eligible dependents to be covered:

Spouse _____	Date of Birth _____
name	month day year
Children _____	Date of Birth _____
name	month day year
_____	Date of Birth _____
name	month day year
_____	Date of Birth _____
name	month day year

- NO**, I do not want basic Health Benefits and understand that I will also not be entitled to Dental and Vision coverage nor be entitled to elect these coverages at a later date.

Signed: _____

Date _____

Signature
of Spouse: _____

Date _____

THE NATIONAL ELEVATOR INDUSTRY PENSION PLAN

PART C

HEALTH COVERAGE AND LIFE INSURANCE BENEFITS FOR DISABILITY RETIREES ONLY AND HEALTH COVERAGE BENEFITS FOR THEIR ELIGIBLE DEPENDENTS PROVIDED BY THE HEALTH BENEFIT PLAN (also see Part D)

Under the terms of the National Elevator Industry Health Benefit Plan, you may continue your life insurance coverage and basic Health benefits for yourself and your spouse and eligible children (with the exception of Weekly Indemnity Insurance, Dental and Vision coverage) until you reach age 65 by authorizing a monthly deduction from your pension benefit. After you attain age 65, Health Benefits (that is, all benefits except Life Insurance and Weekly Indemnity Insurance) are available to you, your spouse and eligible children, as well as Dental and Vision coverage if you were covered by it prior to age 65. See Part D for Dental and Vision coverage. Medicare entitlement commences after Social Security Disability benefits have been paid for 24 months. Medicare will be your primary payer after these 24 months or the first day of the month in which the beneficiary turn age 65, the earlier of the two. You must enroll in Medicare Parts A & B to avoid a gap in coverage. In this regard, see your Health Benefit Plan Summary under "Co-ordination with Medicare."

CHECK ONE ONLY

- YES, deduct from my pension the cost of basic Health Benefit coverage under the National Elevator Industry Health Benefit Plan. I make this authorization voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly benefit, or any portion thereof, to the National Elevator Industry Health Benefit Plan. I understand that the National Elevator Industry Health Benefit Plan has no enforceable right against the National Elevator Industry Pension Plan or to any part of my pension benefit.

Provide names and date of birth of eligible dependents to be covered:

Spouse name Date of Birth month day year
Children name Date of Birth month day year
name Date of Birth month day year
name Date of Birth month day year

- NO, I do not want the basic Health Benefits and understand that I will also not be entitled to Dental and Vision coverage or life insurance coverage nor be entitled to elect these coverages at a later date.

Signed: _____

Date _____

Signature of Spouse: _____

Date _____

PART II - BENEFIT ELECTION

Section A. Election of Benefit Form- Please review the attached estimated pension calculation sheet and read the attached explanations of the benefit options carefully before you make your selection. If you would like additional information, please contact The Benefits Office. **ALL APPLICANTS MUST SIGN AND DATE THIS PAGE.**

MARRIED APPLICANTS SELECT ONE OF THE FOLLOWING BENEFIT FORMS (Initial One):

I hereby select the following benefit payment form (initial one):

- a. 1. _____ 50% Surviving Spouse Pension Only
- 2. _____ 50% Surviving Spouse Pension with 5 Year Certain and Life Option
- 3. _____ 50% Surviving Spouse Pension Form with 10 Year Certain and Life Option

- b. 1. _____ 75% Surviving Spouse Pension Only
- 2. _____ 75% Surviving Spouse Pension with 5 Year Certain and Life Option
- 3. _____ 75% Surviving Spouse Pension with 10 Year Certain and Life Option

- c. 1. _____ 100% Surviving Spouse Pension Only
- 2. _____ 100% Surviving Spouse Pension with 5 Year Certain and Life Option
- 3. _____ 100% Surviving Spouse Pension with 10 Year Certain and Life Option

- d. _____ Straight Life Benefit Form

UNMARRIED APPLICANTS SELECT ONE OF THE FOLLOWING BENEFIT FORMS (initial)

- a. _____ Straight Life Benefit Form Only
- b. _____ Straight Life Benefit Form with 5 Year Certain and Life Option
- c. _____ Straight Life Benefit Form with 10 Year Certain and Life Option

If any of the 5 or 10 Year Certain and Life Options are selected, then any benefits payable after my death should be made to **(PRIMARY BENEFICIARY)-Must be spouse if married:**

Name _____ SS# _____ Relation _____

Address _____

Date of Birth _____

The **ALTERNATE BENEFICIARY** (One Only) of the 5 and 10 Year Certain and Life is:

Name _____ SS# _____ Relation _____

Address _____

Date of Birth _____

APPLICANT'S SIGNATURE _____ **DATE** _____

Section B. Certification of Marital Status (TO BE COMPLETED BY ALL APPLICANTS)

I understand that the law provides that if I am married on the Effective Date of my pension, my spouse must be provided a pension for his or her life after I die unless my spouse and I elect to waive the spousal benefit within the 180-day period ending on my Pension Effective Date. I understand that this spousal benefit is automatically provided by the plan as a 50% Surviving Spouse Pension Benefit. Finally, I understand that I may change my election by writing the Benefits Office at any time before the Effective Date of my pension.

I certify that (Check One):

- I am married.
- I am married and the person signing Section G - Spouse's Consent to Waiver of Survivor Benefits - is my legal spouse. (Complete Sections C)
- I was never married.
- I was previously married but I am not legally married at this time. (Complete Section D)
- I am married but that I am unable to locate my spouse. (You will be required to complete an additional form to be provided by the Benefits Office.)

I understand that the Benefits Office may make inquiries about my marital status with various organizations and individuals and I consent to such inquiries and the release of any information about my past or present marital status from my employers, my Local and International Union and any other organization or individual which may have such information.

Section C. Information About Your Spouse (TO BE COMPLETED BY MARRIED APPLICANTS)

Spouse's Name _____
Give your spouse's full name, including maiden name. Example: Jane Doe Smith

Spouse's Date of Birth _____

Date of Marriage _____ Where Married _____
City and State

Spouse's Social Security Number _____

Section D. Details of Prior Marriages (COMPLETE IF APPLICABLE – member only)

Name of Spouse (including maiden name) _____

Date of Marriage _____ Where Married _____

This marriage ended by (check one):

Death of Spouse on: _____ (Attach copy of death certificate)

Divorce on: _____
(For member only, attach copy of divorce decree, property settlement agreement and any domestic relations order dealing with your former spouse's rights to your pension benefit.)

NOTE: If you had more than one prior marriage, supply the same information as above on a separate sheet of paper and attach.

Do you have a Qualified Domestic Relations Order or have one in the process of being filed, assigning a portion of your pension to an Alternate Payee? (If you answer yes, please attach a copy of the order.)
 yes no

Section E. Designation of Beneficiary for Death Benefits, Life Insurance Benefits, and Return of Personal Contributions

Instructions:

- You can designate more than one individual as your beneficiary. If only one individual is designated, he or she will receive the full amount. If you designate more than one beneficiary, be sure to indicate the percentage each beneficiary will receive, the total of which must equal 100%. If you do not indicate the percentage each beneficiary will receive, they will share equally.
- If you do not designate a beneficiary or if all of your beneficiaries predecease you, benefits will be paid to the individuals and in the order provided in the Pension Plan, or in the Health Benefit Plan, whichever is appropriate.

Lump Sum Death Benefit: The National Elevator Industry Pension Plan provides for the payment of a Lump Sum Death Benefit totaling \$5,000 to your named beneficiary or beneficiaries. However, under the Plan, the Lump Sum Death Benefit is not payable to the designated beneficiary of a retired employee receiving a Disability Pension who is under 65 and entitled to a life insurance benefit under the National Elevator Industry Health Benefit Plan. **THIS SECTION MUST BE COMPLETED BY ALL APPLICANTS.**

Name, Address and Phone Number of Beneficiary	Social Security Number	Relationship	Percentage
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Life Insurance Benefits Payable to Disability Pensioners Under Age 65: In the case of a Disability Pensioner under age 65 who is eligible for health coverage, life insurance benefits are payable to your named beneficiary or beneficiaries in the amount of \$40,000 from the National Elevator Industry Health Benefit Plan. Accidental Death benefits are also payable if you die in a covered accident.

Name, Address and Phone Number of Beneficiary	Social Security Number	Relationship	Percentage
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Refund of Personal Contributions: In the event of your death and the death of your spouse, if applicable, prior to the time your total pension payments equal or exceed the value of your personal contributions and accrued interest, your beneficiary or beneficiaries are entitled to a refund of the excess. (Refer to Pension Plan Summary Plan Description for further explanation.) A statement of the amount of your personal contributions and the interest credited will be provided on the Calculation Sheet sent to you with your first pension payment. **THIS SECTION MUST BE COMPLETED BY ALL APPLICANTS.**

Name, Address and Phone Number of Beneficiary	Social Security Number	Relationship	Percentage
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APPLICANT'S SIGNATURE _____ **DATE** _____

Section F. Employee's Statement (PLEASE READ CAREFULLY BEFORE SIGNING. TO BE SIGNED BY ALL APPLICANTS)

I hereby consent to payment of my benefit from the National Elevator Industry Pension Plan in the form I have elected on page 8 of this application. The information I have provided on this application is true and correct to the best of my knowledge and belief. The Trustees shall have the right to recover payments made to me that are based on a false statement.

I have read the Explanation of Benefit Election form which was sent with this application.

I understand that if I am now married and if I have elected a Straight Life Benefit, it means that no monthly pension benefits will be paid to my spouse by the Plan after my death. My spouse may receive the Lump Sum Death Benefit and/or a Refund of Personal Contributions if I have designated my spouse as a beneficiary for such benefits and such benefits would be paid under the terms of the Plan following my death.

I further understand that I can change my election of a pension benefit form by writing to the Benefits Office BEFORE the Effective Date of my pension. I also understand that my election of a benefit form may not be changed on or after the Effective Date of my pension.

I hereby designate the individual(s) listed in Section E, as my beneficiary(ies) to receive the benefits, if any, payable at my death under the rules of the Plan.

SIGNATURE OF APPLICANT

DATE

Section G. Spouse's Consent to Applicant's Election of a Benefit Form other than the 50% Survivor Benefits. (TO BE COMPLETED ONLY IF MARRIED AND IF A BENEFIT OTHER THAN THE 50% HUSBAND AND WIFE BENEFIT HAS BEEN ELECTED BY THE EMPLOYEE.)

I, _____, am the spouse of the above-named Employee.

I have reviewed my spouse's election of a benefit other than the 50% Surviving Spouse Pension (a.1.) in Section A of this form. I hereby consent to my spouse's selection of an optional benefit form. **I understand that if a Straight Life Benefit has been elected, I will not receive monthly pension benefits from the Plan after my spouse's death. Additionally, I understand I will not be eligible for continued Health Benefit Plan benefits after my spouse's death unless I am now eligible and I have been covered by the Health Benefit Plan for at least 10 years immediately prior to my spouse's death.** Regardless of the benefit form elected, I may receive a Lump Sum Death Benefit and/or Refund of Personal Contributions if I am the designated beneficiary at the time of my spouse's death and such benefits are payable under the terms of the Plan. I further understand that if my spouse has elected a Straight Life Benefit, the benefits paid to my spouse while he or she is living will be higher than they would be if I had the protection of the Surviving Spouse Pension Benefit. I have also reviewed my spouse's designation of a beneficiary in Section E of this form. I consent to my spouse's designation of a beneficiary. I understand that such designation cannot be changed or revoked without my consent.

Date

Spouse's Signature

State of _____)

ss:

County of _____)

On the _____ day of _____, 20____, before me came _____ known to me to be the person described in and who executed the foregoing statement, and (s)he duly acknowledged to me that (s)he executed the same.

(Seal)

Notary Public

My Commission Expires _____

THE NATIONAL ELEVATOR INDUSTRY PENSION PLAN ENROLLMENT FORM FOR DIRECT DEPOSIT OF PENSION PAYMENTS

THIS FORM MUST BE COMPLETED IN ORDER FOR YOU TO RECEIVE YOUR PENSION PAYMENT BY DIRECT DEPOSIT. Unless you notify the Benefits Office that you want to receive your pension payment by check, your pension payments will be made by direct deposit once this form has been processed by our office. If you wish to receive your pension payment by check rather than direct deposit, please carefully review “Considering Receiving Your Pension Payment by Check Rather than Direct Deposit?” in Section 1 below and call the Benefits Office as soon as possible. **For details and requirements regarding the enrollment process please see “Section 2: Enrolling in Direct Deposit” below.**

Section 1: Considering Receiving Your Pension Payment by Check Rather than Direct Deposit?

The National Elevator Industry Pension Plan has developed a dependable DIRECT DEPOSIT service under which we will deposit your pension payments in your checking or savings account (we cannot load debit or cash cards). With Direct Deposit you can be assured that your money will be in your account on the first business day of each month for immediate use. Other advantages of Direct Deposit include: (1) avoids mail delays; (2) eliminates the possibility that your pension check will be lost or stolen; (3) allows you to be away from home without delay in having your benefit available to you; and (4) eliminates a special trip to the bank each month.

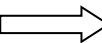
Section 2: Enrolling in Direct Deposit

You must complete the **Enrollment Form for Direct Deposit of Pension Payments** and return the form to the Benefits Office. Once received, your direct deposit request will be processed, and your account information confirmed. **PLEASE NOTE: You will continue to receive your check via mail while this review takes place. You will receive written confirmation regarding your enrollment. Direct deposit to your requested bank account usually starts the SECOND month following our receipt of your direct deposit enrollment form.**

Once Direct Deposit is established, you will receive a monthly **Notice of Deposit** which is a check stub showing the amount of pension monies deposited into your account, any deductions you have elected to have withheld from your pension, and year-to-date figures. **It is recommended that these stubs be retained for tax planning purposes.**

Section 3: Opting Out of Direct Deposit / Electing to Receive Your Payment by Check

If you have certain circumstances where Direct Deposit is not feasible, such as you have retired outside the United States, are in a nursing home, or other extenuating circumstances please call the Benefits Office to discuss your circumstances and request pension payment by check. It is our policy to mail all checks two business days prior to the scheduled pay date. **Please be aware that once payments are sent to the Post Office, we have no control over the length of delivery time and your pension check may not be delivered on the first of the month. Please be patient as checks are frequently received late and a replacement check will only be issued after the 8th day of the month.** **SEE REVERSE SIDE FOR APPLICATION**



If you have any questions concerning direct deposit, or require your pension payment by check please contact our office at 1/800-523-4702: Follow Prompts #4, #5, #2

TO ENROLL IN DIRECT DEPOSIT COMPLETE AND RETURN THIS FORM TO:

National Elevator Industry Pension Plan
Attn: Finance Department
19 Campus Blvd, STE 200
Newtown Square, PA 19073-3288
Fax (610) 557-4516 or FFax@neibenefits.org

APPLICANT INFORMATION: COMPLETE ALL FIELDS BELOW INCLUDING SIGNATURE AND DATE

SOCIAL SECURITY NUMBER (last 4 digits only) or ALT ID: _____

PENSIONER'S NAME _____

ADDRESS _____

PHONE NUMBER (____) _____

ACKNOWLEDGEMENT: I am the payee under the above Social Security/Alt ID number and I hereby request that until further written notice from me is filed with Pension Plan Administrator, all payments be directly deposited in the account at the Bank designated below. I authorize the Bank designated to debit my account and to refund any overpayments to the National Elevator Industry Pension Plan.

PENSIONER'S SIGNATURE _____ DATE _____

BANK INFORMATION: CHOOSE ONE (1) OPTION BELOW AND FOLLOW THE INSTRUCTIONS TO ENROLL

CHECK THIS BOX TO DEPOSIT YOUR FUNDS TO A CHECKING ACCOUNT

****You MUST attach a copy of a blank check marked "VOID" in order for this request to be processed****

CHECK THIS BOX TO DEPOSIT YOUR FUNDS TO A SAVINGS ACCOUNT

****You MUST complete the information below in order for this request to be processed****

• **9-DIGIT ACH BANK ROUTING NUMBER:** _____

• **SAVINGS ACCOUNT NUMBER:** _____

• **NAME AND ADDRESS OF BANK TO WHICH PAYMENT IS TO BE MADE:**

Bank Name _____

Address _____

City _____ State _____ Zip Code _____

Bank Telephone Number (____) _____ Extension _____

THE NATIONAL ELEVATOR INDUSTRY PENSION PLAN

**VOLUNTARY AUTHORIZATION OF DIRECT PAYMENT FROM MY
MONTHLY PENSION TO THE NATIONAL ELEVATOR CONSTRUCTORS
POLITICAL ACTION COMMITTEE (“NECPAC”)**

I hereby authorize and direct the National Elevator Industry Pension Plan to deduct from my monthly pension benefit the amount set forth below and to remit that amount on a continuing basis to the National Elevator Constructors Political Action Committee (“NECPAC”).

I understand that I can contribute more or less than the amount set forth below through other methods such as direct contributions to NECPAC. I further understand that this is a voluntary contribution and that whether or not I make any contributions to NECPAC shall in no way affect my rights under the National Elevator Industry Pension Plan or impact my rights under the Constitution and By-Laws of the International Union of Elevator Constructors.

I understand that the money I contribute will be used for political purposes and I understand that all or some of the amount I contribute may be used to influence the election or defeat of candidates in elections for federal, state or local office or to address political issues and referendums of public importance.

This authorization has been voluntarily made, and I understand that I may revoke this authorization at any time by notifying the National Elevator Industry Pension Plan in writing of my revocation.

-
- YES**, please deduct from my monthly pension benefit the amount of: \$ _____, and remit that amount on a continuing basis to the National Elevator Constructors Political Action Committee (“NECPAC”). I make this voluntarily and understand that it may be revoked at any time. By this authorization, I am not assigning my monthly pension benefit, or any portion thereof, to NECPAC. I understand that NECPAC has no enforceable right against the National Elevator Industry Pension Plan or to any part of my pension benefit.

Date

Signature

Print Name

Contributions or gifts to NECPAC are not tax deductible for federal income tax purposes.

DOCUMENTATION CHECKLIST

Please refer to your pension application instructions to determine what documentation you should submit to the Benefits Office. **Please send PHOTOCOPIES ONLY. Originals will not be returned to you.** If you are not able to enclose one or all of the documents with your pension application, please give your reasons below for each one. All documentation applicable to you must be forwarded to the Benefits Office. The process of your application may be delayed pending receipt of all documentation.

Please check if applicable documents enclosed:	YES	or	NO
MEMBER’S BIRTH CERTIFICATE	<input type="checkbox"/>		<input type="checkbox"/>
SPOUSE’S BIRTH CERTIFICATE	<input type="checkbox"/>		<input type="checkbox"/>
MARRIAGE CERTIFICATE	<input type="checkbox"/>		<input type="checkbox"/>
DIVORCE DECREE(S) – Members’ divorce only	<input type="checkbox"/>		<input type="checkbox"/>
SOCIAL SECURITY DISABILITY AWARD (Full Copy)	<input type="checkbox"/>		<input type="checkbox"/>
DD214 FORM (must have been in Covered Employment immediately prior to <u>and</u> after military service)	<input type="checkbox"/>		<input type="checkbox"/>
TERMINATION LETTER FROM EMPLOYER (If Salaried/Management)	<input type="checkbox"/>		<input type="checkbox"/>
QUALIFIED DOMESTIC RELATIONS ORDER	<input type="checkbox"/>		<input type="checkbox"/>
OWNER (need proof of termination of ownership)	<input type="checkbox"/>		<input type="checkbox"/>

REASONS FOR DELAY OF EACH DOCUMENT NOT ENCLOSED:
