

MASSACHUSETTS LABORERS' PENSION FUND

14 NEW ENGLAND EXECUTIVE PARK, SUITE 200
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TELEPHONE (781) 272-1000 • FAX (781) 272-2226

DISABILITY RETIREMENT DECLARATION

Name

Social Security No.

In retiring on a Disability Pension from the Massachusetts Laborers' Pension Fund, I declare that I will be bound by the Pension Plan rules and regulations and that:

- 1. I will not engage in any Covered Employment whatsoever.**
- 2. I will not engage in any other employment or other personal gainful activity for which I receive more than \$500 a month.**
- 3. I understand if I work in violation of Items 1 or 2, I may be disqualified at the sole discretion of the Trustees from receiving or being entitled to benefits from the Pension Plan.**
- 4. I understand that I may request a ruling from the Trustees on whether a particular type of contemplated employment will be in violation of Item 1.**
- 5. I will submit to periodic medical examinations in accordance with the direction of the Trustees.**
- 6. I hereby certify that I am not eligible for, or receiving any disability benefits from any jointly administered, collectively bargained Welfare Fund, or other organization due to a job related illness or injury.**

Date

Signature