# MASSACHUSETTS LABORERS' PENSION FUND

P.O. BOX 1501 • 1400 DISTRICT AVENUE • SUITE 200
BURLINGTON, MASSACHUSETTS 01803
TELEPHONE (781) 272-1000 • FAX (781) 272-2226

## APPLICATION FOR SURVIVOR'S BENEFIT

**INSTRUCTIONS:** *Please read this application carefully and PRINT all answers. Mail the completed application to the Fund Office along with the original Death Certificate, the member's proof of age, and if applicable, your marriage certificate and your proof of age, and a copy of your driver's license and social security card.*

## APPLICANT'S STATEMENT

### 1. REGARDING THE DECEASED MEMBER

a. Name_____ b. Social Security No._____
LAST FIRST MIDDLE

c. Date of Death_____/_____/_____ (Attach Death Certificate)
MONTH DAY YEAR

d. Date of Birth _____/_____/_____ (Attach proof of age)
MONTH DAY YEAR

e. Local Union Number_____ f. Member Number (from Union Card)_____

g. Date of Initiation into the union_____

h. Did member ever receive Workmen's Compensation for periods of time he was out of work? ____Yes ____No. If "Yes" , please attach any records of this, including the name of Contractor, the Insurance Company, and any records from the Industrial Accident Board. Also include dates of injury and length of compensation.

i. Did member ever receive weekly benefits from the Massachusetts Laborers' Health & Welfare Fund? ____Yes____No

j. Date member last worked under covered employment_____

### 2. REGARDING THE APPLICANT

a. Your name_____ b._____
LAST FIRST MIDDLE (IF WIDOW, GIVE DATE OF MARRIAGE AND ATTACH COPY OF MARRIAGE CERTIFICATE)

c. Your address_____
NUMBER STREET CITY STATE ZIP CODE

d. Your telephone number (_____)_____

e. Your Social Security Number ___/___/___/___/___/___/___/___/___

f. Your Date of Birth_____/_____/_____ (If widow, include proof of age)

g. Your relationship to the deceased member_____

h. If not the widow/widower of the deceased, are you the administrator or executor of the estate of the deceased? ____ Yes ____ No. If "Yes", please send us a legal document to this effect.

I hereby apply for a Survivor's benefit from the Massachusetts Laborers' Pension Fund, and certify that the statements made in this application are true to the best of my knowledge and belief. I understand that a false statement shall be sufficient reason for the denial, suspension or discontinuance of benefits and that the Trustees shall have the right to recover any payments made to me in reliance upon such false statement.

_____ _____/_____/_____

SIGNATURE OF APPLICANT DATE

NOTE: This official form must be used when applying for a pension from this fund. You will be notified in writing that your application has been received by the Fund Office.

You will be notified in writing of the decision made by the Trustees on your application in approximately three to four months.

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INCOME TAX WITHHOLDING • The distributions or withdrawals from this Plan are subject to Federal and State Income Tax withholdings unless you elect otherwise. If you do not notify us that you wish to have taxes withheld, we will withhold Income Tax in accordance with the applicable tax tables.

Please check the appropriate choices below. Please note that even if you elect not to have Income Tax withheld, you are liable for payment of Income Tax on the taxable portion of your monthly pension benefit. You may also be subject to tax penalties under the estimated tax payment rules if your payments or estimated tax and withholding, if any, are not adequate.

___(A) I do not want to have any Federal or State Income Tax withheld from my pension

___(B) I do want Income Taxes withheld from my monthly pension.
(Indicate below the amount of withholding you are selecting)

___(1) Amount in accordance with applicable tax tables.
Number of exemptions: Federal_____ State____
Marital Status: Married_____ Single_____
Married but withhold at higher single rate_____
(2 and 3 do not apply if you have chosen a lump sum settlement)

___(2) $_____Federal $_____State

___(3) _____% Federal _____% State

___(C) I am exempt from Massachusetts income tax withholding because my legal residence (domicile) is elsewhere and the income being paid was not derived from or connected with an occupation, profession, trade or business carried on in Massachusetts.

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## Massachusetts Laborers' Pension Fund
## Direct Deposit Authorization Form

I hereby authorize the Massachusetts Laborers' Pension Fund, hereinafter called the "Fund", to initiate direct deposit credit entries to my ( ) Checking ( ) Savings account (*please select one*) at the bank named below, hereinafter called the "Bank", and to credit the same to such account.

**NAME OF BANK**_____ **BRANCH**_____

**CITY:** _____ **STATE/PROV.**_____**ZIP**_____

**BANK TEL#**_____ **EXT:** _____

**ROUTING #**_____ **ACCOUNT #**_____

If you do not know your account number or routing number, please call your bank and request this information. Be sure to identify whether it is a checking account or savings account.

This authorization is to remain in full force and effect until the "Fund" has received WRITTEN notification from me of its termination in such time and in such manner as to afford the "Fund" and "Bank" reasonable opportunity to act on it.

**PENSIONER/**
**BENEFICIARY NAME:** _____
(Please print)

**PENSIONER/**
**BENEFICIARY Soc. Sec. #:**_____

**PENSIONER/**
**BENEFICIARY**
**SIGNATURE:** _____
(Name) (Date)

**HOME TELEPHONE NO.:** _____ **LOCAL #**_____
(In case we have difficulty with this form)

**NOTE:** All written credit authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in this authorization.

*PLEASE COMPLETE THIS FORM TO RECEIVE YOUR PENSION CHECKS*
**MANDATORY**