AFL HOTEL AND RESTAURANT WORKERS TRUST FUNDS

560 N. Nimitz Hwy., Suite 209 ● Honolulu, Hawaii 96817 ● Fax (808) 537-1074
Phone (808) 523-0199 ● Neighbor Islands Dial Direct 1 (866) 772-8989
HEALTH & WELFARE ● PENSION ● TRAINING

RE: HOTEL UNION & HOTEL INDUSTRY OF HAWAII PENSION PLAN "the Plan"
RETIREMENT PENSION BENEFIT PACKET

Dear Participant,

The attached Application for Retirement Pension Benefit packet must be fully completed, executed and forwarded back to the Plan. All copies of required documents, as described on the List of Acceptable Documents; along with your executed Employer Verification form must also be enclosed with your Application for the Plan to begin processing your benefits.

Please keep in mind, based on information and documents you provide, it may take several months to process your pension application.

Upon completion of your benefit estimates, an Election Form will be sent to you at which time you will then need to "Elect" the type of benefit you wish to receive.

Your application required documentation and completed employer verification must be sent together. If the Plan receives partial documentation, your application will be deemed incomplete, and as such, will be returned to you. Mail to:

Hotel Union & Hotel Industry of Hawaii Pension Plan
c/o Benefit & Risk Management Services, Inc.
560 N. Nimitz Highway, Suite 209/219
Honolulu, Hawaii 96817

If you have any questions, please call us at (808) 523-0199
Neighbor Islands Toll Free (866 772-8989
Email: hiaflinfo@brmsonline.com

HOTEL UNION & HOTEL INDUSTRY OF HAWAII PENSION PLAN

APPLICATION FOR BENEFITS

NAME: _____
LAST FIRST MIDDLE

PREVIOUS NAME, IF ANY: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET or P.O. BOX NO. CITY STATE ZIP CODE

PHONE: _(_____)_____ MOBILE PHONE _(_____)_____

SOCIAL SECURITY NO.: _____-_____-_____

EMAIL: _____

*[**Note**: In providing your mobile phone number, you consent to receive cell phone calls, texts, and other communications from the Plan and its affiliated entities about your Plan benefits.]*

DATE OF BIRTH: _____/_____/_____ SEX: ☐ MALE ☐ FEMALE

U.S. CITIZEN: ☐ YES ☐ NO DATE LAST WORKED IN COVERED POSITION: _____

MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

HAVE YOU EVER BEEN DIVORCED? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE A FILED COPY OF THE DIVORCE DECREE

IS THERE A **DOMESTIC RELATIONS ORDER/PROPERTY SETTLEMENT** IN EFFECT AWARDING A PORTION OF YOUR POSSILBLE PENSION BENEFITS TO YOUR FORMER SPOUSE? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE A FILED COPY OF THE **ORDER**

IF YOU ARE MARRIED, COMPLETE THE FOLLOWING INFORMATION ON YOUR SPOUSE:

NAME: _____ SOC. SEC. NO.: _____

DATE OF BIRTH: _____ DATE OF MARRIAGE: _____

ONE-TIME BENEFICIARY DESIGNATION. If there are any pension benefits payable to you that remain unpaid at the time of your death, the person named below shall be paid those benefits:

FULL NAME: _____ SOC. SEC. NO.: _____

DATE OF BIRTH: _____ SEX: _____ RELATIONSHIP TO PARTICIPANT: _____

ADDRESS: _____
Street or P.O. Box Number City State Zip Code

PARTICIPANT/APPLICANT'S STATEMENT: I certify that the information contained in this application is true and complete to the best of my knowledge and belief. I hereby apply for a benefit under and subject to the provisions of the Hotel Union & Hotel Industry of Hawaii Pension Plan.

_____ _____
Participant / Applicant's Signature Date

BENEFIT OPTIONS

Your benefits will be paid to you in the normal form, at such times as provided for you in the Plan, unless you elect to waive this form of benefit (with your spouse's consent if you are married).

IF YOU ARE NOT MARRIED, the normal form is a **Single Life Annuity Benefit which** provides you with the monthly payments for your life. The benefit payments will cease with the benefit payment for the month of your death.

IF YOU ARE MARRIED, the normal form is an **Automatic Contingent Annuity Benefit** which provides you with a reduced monthly payment for your life, and, upon your death, a monthly payment for your spouse's life equal to 50% of the monthly payment you received prior to your death. If your spouse dies before you, no payments will be made after your death. The amount of reduction is determined based on the age difference between you and your spouse.

You may elect not to receive your benefits in the normal form and instead choose to receive your benefits in one of the optional distribution forms listed below. Your spouse's consent is needed if you elect not to receive your benefits in the normal form.

Your optional forms are as follows:

(1) **Single Life Annuity Benefit.** Under this optional form, you are provided with a monthly pension for your life. The benefits payments will cease with the benefit payment for the month of your death.

(2) **Husband and Wife Pop-Up Benefit.** Under this optional form, you are provided with a *reduced monthly pension for your life and, upon your death, a monthly payment for your spouse's life equal to 50% of the monthly payment you received prior to your death. This option form is similar to the Automatic Contingent Annuity Benefit with the additional feature that if your spouse dies before you, your monthly pension reverts to the full amount of the Single Life Annuity benefit (see Optional Form (1) above). As a result of this "pop-up" feature, there is an additional reduction to the pension amount that is payable while your spouse is living.
*The amount of the reduction is based on the age difference between you and your spouse.

(3) **Qualified Optional Joint & Survivor Pension (for married Participants).** Under this optional form, you are provided with a *reduced monthly pension for your life. When you die, monthly payments will be provided for your spouse's life equal to 75% of the monthly pension you received prior to your death. If your spouse dies before you, payments will cease with the payment for the month in which you die.
*The amount of the reduction is based on the age difference between you and your spouse.

(4) **Contingent Annuity Option Benefit.** Under this optional form, you are provided with a *reduced monthly pension for your life. When you die, monthly payments will be provided to your designated beneficiary, if living. He or she will receive a monthly pension for his or her lifetime equal to 50%, 66 2/3%, or 100%, of the pension amount that you had been receiving prior to your death. Your designated beneficiary may be limited by the Trustees to certain classes of persons but, you choose the person who is to receive the survivor benefit. You also choose the percentage of your monthly pension to be paid to your designated beneficiary (restrictions may apply if the beneficiary is not your spouse). If your designated beneficiary pre-deceases you, the pension payments will cease with the pension payment for the month in which you die. If prior to your actual retirement, you should die or your designated beneficiary pre-deceases you, the election of the option shall become null and void and of no effect.
*The amount of the reduction is based on the age difference between you and your spouse.

(5) **Social Security Option Benefit.** Under this optional form, you are provided with an actuarially adjusted benefit which will provide a greater amount during the period before you become eligible for Social Security benefits (age 62 in most cases) and a reduced amount thereafter so that, as nearly as possible, you will receive a level monthly income for life (taking into account your estimated Social Security benefits). The benefit payments will cease with the benefit payment for the month of your death.

(6) **Cash Lump-Sum Settlement.** This optional form is available only if you leave the United States for **permanent** residence in a foreign country other than Canada. Under this optional form, and upon proper application, you are provided with a lump-sum payment in lieu of a monthly pension. The lump-sum payment is equal in value to the actuarial equivalent of a monthly pension that you would otherwise be entitled to receive. (Proper application for a Cash Lump-Sum Settlement must have been made before retirement to be effective upon your retirement and requires that you have submitted medical evidence satisfactory to the Trustees that you are in reasonable health for a person of your age and documentation of proof of change in your permanent residency.)

HOTEL UNION & HOTEL INDUSTRY OF HAWAII PENSION PLAN

TO THE BOARD OF TRUSTEES:

This is to confirm that I, _____
(PRINT NAME)

Social Security Number: _____

(CHECK ONE)

☐ WISH TO RETIRE THE FIRST DAY OF THE (MONTH) _____ (YEAR) _____ AT AGE _____

☐ WISH TO RETIRE ON THE FIRST DAY OF THE MONTH, SIX MONTHS PRIOR TO THE DATE OF THIS APPLICATION

☐ DO NOT WISH TO SET A RETIREMENT DATE AT THIS TIME (REQUIRED MINIMUM DISTRIBUTION)

PENSION BENEFIT APPLIED FOR: (CHECK ONE)

☐ EARLY (AGE 55 – 64)

☐ NORMAL (AGE 65)

☐ POSTPONED (OVER AGE 65)

☐ DISABILITY (PLEASE CONTACT THE ADMINSTRATIVE OFFICE FOR ELIGIBLITY)

☐ REQUIRED MINIMUM DISTRIBUTION (PLEASE CONTACT THE ADMINSTRATIVE OFFICE FOR ELIGIBLITY)

INDICATE BELOW THE BENEFIT OPTIONS FOR WHICH YOU WOULD LIKE TO HAVE ESTIMATES DONE:

☐ SINGLE LIFE ANNUITY BENEFIT

☐ HUSBAND AND WIFE POP-UP BENEFIT

☐ QUALIFIED OPTIONAL JOINT & SURVIVOR PENSION (for married Participants)

☐ CONTINGENT ANNUITY OPTION BENEFIT (Provide Birth Certificate & Marriage Certificate if applicable)

Name of Contingent Beneficiary: _____

Date of Birth: _____ Soc. Sec. No.: _____ Relationship: _____

Address: _____

☐ SOCIAL SECURITY OPTION BENEFIT (Provide Earnings Statement from Social Security Administration)

☐ CASH LUMP-SUM SETTLEMENT (PLEASE CONTACT THE ADMINSTRATIVE OFFICE FOR ELIGIBLITY)

_____
Signature

_____
Date

LIST OF ACCEPTABLE DOCUMENTS

PROOF OF AGE MUST BE FURNISHED BEFORE RETIREMENT BY ALL APPLICANTS
THE SAME IDENTIFICATION RULES APPLY TO YOUR SPOUSE AND YOUR CONTINGENT BENEFICAIRY.
YOU WILL ALSO NEED TO PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE.

ITEMS ARE LISTED BY ORDER OF PREFERENCE. IF YOU ARE UNABLE TO SUPPLY **A DOCUMENT** SHOWN UNDER GROUP I, **SUBMIT AT LEAST TWO OF THE OTHER DOCUMENTS SHOWN UNDER GROUP II**. (THE FUND MAY REQUEST ADDITIONAL PROOF IF A CONFLICT EXISTS WITH OTHER INFORMATION OBTAINED).

I SUBMIT THE FOLLOWING PROOF OF AGE:

GROUP I (ONE PROOF REQUIRED)

- BIRTH CERTIFICATE
- BAPTISMAL CERTIFICATE, SIGNED BY CHURCH OFFICIAL
- CERTIFIED BIRTH REGISTRATION
- CERTIFICATION OF RECORD OF AGE BY THE U.S. CENSUS BUREAU
- HOSPITAL BIRTH RECORD, SIGNED BY THE HOSPITAL ADMINISTRATION
- FOREIGN CHURCH OR GOVERNMENT RECORD
- SIGNED STATEMENT OF PHYSICIAN OR MIDWIFE IN ATTENDANCE
- NATURALIZATION RECORD
- IMMIGRATION RECORD

GROUP II (TWO PROOFS REQUIRED)

- MILITARY RECORD
- PASSPORT
- CERTIFIED SCHOOL RECORD
- CERTIFIED VACCINATION RECORD
- INSURANCE POLICY SHOWING DATE OF BIRTH OR AGE
- CERTIFIED MARRIAGE RECORD, SHOWING DATE OF BIRTH OR AGE
- OTHER RECORDS SUCH AS SIGNED STATEMENTS FROM PERSONS WHO HAVE KNOWLEDGE OF THE DATE OF BIRTH.

ALL APPLICANTS MUST COMPLETE THIS EMPLOYMENT SECTION FULLY

Employers	Hotel Property Address	Local Union #	Dates of Employment From (Mo/Yr) To		Position Held (Housekeeper, Maintenance, Wait help)

NOTE: IF YOU HAVE ANY BREAKS IN SERVICE DUE TO MILITARY SERVICE, BE SURE TO FURNISH DISCHARGE PAPERS SHOWING **BOTH INDUCTION AND DISCHARGE DATES**.

ARE YOU CURRENTLY EMPLOYED? (CHECK ONE) ☐ YES ☐ NO

IF YES, NAME OF EMPLOYER: _____

Participant:

Please have your Employer complete this form and return to you for submission with your Pension Application.
The Plan will NOT ACCEPT Employer Verification Forms sent directly from Human Resources to the Plan.

EMPLOYER VERIFICATION

Employees Name: _____ SSN: _____

Hotel Employers Name: _____

JOB CLASSIFICATION	DATE HIRED	LAST DAY WORKED

Termination Date: _____

I CERTIFY THAT THE ABOVE-NAMED INFORMATION IS TRUE AND CORRECT TO BE THE BEST OF MY KNOWLEDGE AND ON RECORD.

Employer: Please complete and return to your bargained employee/associate for submission with application.

Authorized Person Name: _____ Date: _____

Signature of Authorized Person: _____
Title: _____ Contact: _____

****

To assist with expediting pension benefit

(below is optional for Employer to complete at this time. The Plan will require this information at a later date)

Please indicate the applicable period(s) and number of non-work hours paid, if any, after last day worked.

SICK LEAVE	PERIOD		HOURS		DATE PAID	
HOLIDAY	PERIOD		HOURS		DATE PAID	
VAC. TAKEN	PERIOD		HOURS		DATE PAID	
TERMINAL VAC.	PERIOD		HOURS		DATE PAID	

Please indicate reason(s) for absences (i.e. Industrial, Military Leave, Sick Leave, T.D.I., Workers Comp., etc,)
EXCUSED LEAVE OF ABSENCES WITHOUT PAY

PERIODS	REASON	ACTUAL DATES FROM/THROUGH