

HAWAII TEAMSTERS TRUST FUNDS

560 N. Nimitz Highway, Suite 209, Honolulu, Hawaii 96817
Phone (808) 523-0199 • Toll-Free 1 (866) 772-8989 • Fax (808) 537-1074

Hawaii Truckers Pension Plan • Teamsters Health & Welfare Trust Fund • Teamsters Legal Services Plan • Teamsters Training and Opportunity Program

RE: HAWAII TRUCKERS-TEAMSTERS UNION PENSION PLAN
PENSION APPLICATION

Dear Member:

Pursuant to your request, we have enclosed an Application for Retirement Benefits.

Please complete the Application and return it, with copies of the necessary documents, to the Trust Fund Office in the enclosed self-addressed return envelope.

Please be aware that it may take several months to process your pension application.

Upon completion of your Retirement Benefit estimates, we will send you the Election form which you will then elect the type of benefit form you would like to receive.

If you have any questions regarding your retirement, please feel free to contact the Trust Fund Office, Pension Department.

Sincerely,

Pension Department

Enclosures

cc: File

HAWAII TRUCKERS – TEAMSTERS UNION 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

SOCIAL SECURITY NO.: _____ - _____ - _____ PHONE: (____) _____

DATE OF BIRTH: ____/____/____ SEX: MALE FEMALE

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

MARTIAL 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 POSSIBLE PENSION BENEFITS TO YOUR FORMER SPOUSE? YES NO
IF YES, PLEASE PROVIDE A FILED COPY OF THE **ORDER**

PENSION BENEFIT APPLIED FOR: (CHECK ONE)

NORMAL (AGE 65) *ATTAINMENT OF AGE 70 ½ *DISABILITY EARLY (AGE 55 OR OVER)

*PLEASE CONTACT THE ADMINISTRATIVE OFFICE TO VERIFY YOUR ELIGIBILITY

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 hereby request retirement under the Hawaii Truckers – Teamsters Union Pension Plan. I will immediately notify the Hawaii Truckers – Teamsters Union Pension Plan if I return to employment in the same industry in the same trade or craft in Hawaii. I understand that my monthly pension payments will be suspended for any calendar month of such employment in which I worked 40 or more hours.

**Falsifying information may lead to legal intervention.*

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 the 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) **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.
- (3) **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 you 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.
- (4) **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.

HAWAII TRUCKERS – TEAMSTERS UNON 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 FOLLOWING THE DATE OF THIS APPLICATION
- WISH TO RETIRE THE FIRST DAY OF THE MONTH IMMEDIATELY FOLLOWING MY ATTAINMENT OF NORMAL RETIREMENT AGE
- WISH TO RETIRE THE FIRST DAY OF THE MONTH SIX MONTHS PRIOR TO THE DATE OF THIS APPLICATION
- THE FIRST DAY OF THE (MONTH) _____ (YEAR) _____ AT AGE _____
- DO NOT WISH TO SET A RETIREMENT DATE AT THIS TIME (ATTAINMENT OF AGE 70 ½)

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

- 1. [] SINGLE LIFE ANNUITY BENEFIT
- 2. [] QUALIFIED OPTIONAL JOINT & SURVIVOR PENSION (for married Participants)
- 3. [] CONTINGENT ANNUITY OPTION BENEFIT (Provide Birth Certificate & Marriage Certificate if applicable)
Name of Contingent Beneficiary: _____
Date of Birth: _____ Soc. Sec. No.: _____ Relationship: _____
Address: _____
- 4. [] SOCIAL SECURITY OPTION BENEFIT (Provide Earnings Statement from Social Security Administration)

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 BENEFICIARY.
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.) ALL DOCUMENTS WILL BE RETURNED TO YOU AFTER RECORDING BY THE FUND OFFICE.

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	Trucking Company Address	Local Union #	Dates of Employment From (Mo/Yr) To		Position Held (Business Agent, Driver)

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? IF SO, WHERE?

**Falsifying information may lead to legal intervention.*