U. A. LOCAL NO. 447 PENSION PLAN

APPLICATION FOR RETIREMENT BENEFITS
TO ALTERNATE PAYEE

Instructions:
1. PRINT all information in **ink**. Do not use pencil.
2. Sign and date the application.
3. Submit copies of the following documents: (1) your birth certificate; (2) qualified domestic relations order and judgment of dissolution and marital property settlement; (3) completed Federal and State withholding tax forms.
4. Mail or deliver the completed application and attachments to the Trust Fund Office.

INCORRECT OR INCOMPLETE INFORMATION WILL DELAY PAYMENT OF YOUR BENEFITS.

PARTICIPANT INFORMATION:

1. Name_____
   Last First Middle

2. Social Security Number_____ 3. U. A. Local No._____

ALTERNATE PAYEE INFORMATION:

4. Name_____
   Last First Middle

5. Address_____
   No. and Street Apt. No.

   _____
   City State Zip Code

6. Address to which pension checks are to be sent if different from address above. For direct deposit to your bank account, submit a voided check with your application.

   _____
   No. and Street City State Zip Code

7. Birth Date_____ 8. Phone No. ( )_____

9. Social Security Number_____

10. Commencement date requested_____

If you are receiving your share of the participant's benefits in the form of shared payments under a benefit option selected by the participant, skip to item 13.

11. Form of benefit (Please refer to the attached analysis sheet for complete information):

a. _____ Life Annuity (Monthly payments for your lifetime with a guaranteed minimum of 36 monthly payments plus 6 monthly payments to your beneficiary after your death. If you die before receiving 36 payments, your beneficiary will receive the remainder of the 36 payments plus 6 monthly payments; if you die after receiving 36 or more payments, your beneficiary will receive 6 monthly payments.)

b. _____ 10 Year Certain (Monthly payments for your lifetime with a minimum guarantee of 10 years of payments)

12. Beneficiary Designation: _____

Name of Beneficiary_____ Relationship_____

Birth Date_____ SS#_____ Telephone ( )_____

Beneficiary's Address _____
No. and Street Apt. No.

_____
City State Zip Code

13. I hereby swear or affirm under penalty of perjury under the laws of the State of California that all of the above statements are true and correct to the best of my knowledge. I understand that the Board of Trustees has the right to recover any benefits paid to me because of a false statement.

_____ _____
Alternate Payee Signature Date