STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568

Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301

www.Local39Benefits.org * l39pension@hsba.com

PENSION BENEFIT OPTION ELECTION FORM

Participant's Name: ______________________________ SSN#: ________________________

Spouse Name: __________________________________ SSN#: ________________________

I hereby acknowledge that I understand my rights to benefits from the Stationary Engineers Local 39 Pension Fund. I hereby elect to receive my monthly benefits in the form indicated below. **I understand that, if I am married on my effective date, I will receive my benefits in the 50% Joint and Survivor form UNLESS I elect another form of benefit and, if I elect to receive benefits in one of the alternate forms of benefit, my spouse consents to my waiver of the 50% Joint and Survivor form by signing the Spousal Consent to Waiver of 50% Joint and Survivor Form at the bottom of this form.**

I hereby choose to receive my Pension Benefit in the option as indicated below (check one):

- ❑ **50% Joint and Survivor***
- ❑ **75% Joint and Survivor***
- ❑ **50% Joint and Survivor with popup***
- ❑ **75% Joint and Survivor with popup***
- ❑ **Single Life Annuity form***

By signing this form, my spouse and I understand that once benefits commence, the benefit option cannot be changed to any other form of benefits. Also, under the joint and 50%, and 75%, survivorship options, if my Spouse dies before me, an alternate beneficiary may not be designated. In addition; should my spouse and I divorce after my retirement commencement date, I understand that the spouse listed above will continue to be eligible for the survivor benefit chosen, despite any future marriage into which I may enter.

We acknowledge receipt of the notice forms provided by the Trustees of the Plan explaining the joint and survivorship options, and we understand them, and we also acknowledge that we have had the opportunity to consult with advisors of our choosing with regard to this notice.

Participant's Signature: ____________________________________ Date: ________________

Spouse's Signature: ____ Date: ________________

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568

Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301

www.Local39Benefits.org * l39pension@hsba.com

RELATIVE VALUE NOTICE

Although the amount of the monthly benefit payable to you is different for each of the optional forms of benefit available under the Plan, the relative value of each of the optional forms of benefits offered under the Plan are approximately equal in value to the 50% joint and survivor annuity.

The relative value comparison is intended to allow you to compare the total value of distributions paid in different forms. The relative value comparison was made by converting the value of each optional form of benefit available to the 50% joint and survivor annuity as the common form. This conversion uses interest and life expectancy assumptions. The relative value of a benefit is determined by projecting the total benefits expected to be paid to you and a joint annuitant, if applicable, based upon standard mortality tables and discounted for 5.5% interest. All comparisons are based on average life expectancies. The value of payments ultimately made under an annuity form of benefit will depend upon your actual longevity. You can request details regarding the actuarial assumptions used to calculate the relative value of optional forms of benefit by contacting the Administrative Office.

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568

Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301

www.Local39Benefits.org * l39pension@hsba.com

SPOUSAL CONSENT WAIVER OF 50% JOINT & SURVIVOR FORM OF BENEFIT

I am the legal spouse of ____. (Participant's Name)

With my consent, my spouse has elected to waive the normal form of benefit in the 50% Joint & Survivor Form and has instead elected an alternative form of benefit as offered by the plan and chosen above.

Spouse Name: ______________________________________ SSN#: __________________________

Spouse Signature:___________________________________ Date: ___________________________

(Must be notarized)

TO BE COMPLETED BY NOTARY PUBLIC

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _________________________________ County of ____________________________________

On _____________________, before me,____

(insert name and title of the office)

Personally appeared ____ , who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity (ies), and by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the state of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

____

Signature of Notary Public

My Commission expires: _________________________

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568
Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301
www.Local39Benefits.org * l39pension@hsba.com

WAIVER OF 30-DAY NOTICE

I, ________________________________ , (Participant) hereby acknowledge that I have been informed that Federal law prohibits the Fund from paying benefits to me until at least 30 days after my spouse and I have received a written explanation of the 50% Joint and Survivor benefit form, including my right to waive that form with the written consent of my spouse and the effect of such a waiver and the right my spouse and I each have to revoke that waiver and consent. I have also been informed that I may waive that 30-day notice period and instead elect a 7-day notice period, which will permit the Fund to commence payment of benefits to me no less than 7 days after my spouse and I received the written explanation, provided my spouse also consents in writing to waiver of the 30-day notice period.

☐ I elect to waive the 30-day notice period.

_______________________________________ _______________________________
Participant Signature Date

TO BE COMPLETED BY NOTARY PUBLIC

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _________________________________ County of _____________________________________

On ______________________, before me, ____
(insert name and title of the office)

Personally appeared ____ , who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity (ies), and by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the state of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

____
Signature of Notary Public

My Commission expires: _________________________

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568
Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301
www.Local39Benefits.org * l39pension@hsba.com

SPOUSAL CONSENT WAIVER OF 30-DAY NOTICE

I am the legal spouse of ____, (Participant). I acknowledge that I have been informed that my spouse wishes to waive the requirement that we receive, at least 30 days before the Fund pays benefits to my spouse, a written explanation of the 50% Joint and Survivor benefit form, including my spouse's right to waive the 50% Joint and Survivor benefit form with my written consent, the effect of such a waiver and the right my spouse and I each have to revoke that waiver and consent, and to elect instead a 7 day notice period as permitted by federal law. I hereby consent to the election of my spouse to waive the 30-day notice period.

____ Spouse Signature

_________________________________ Date

TO BE COMPLETED BY NOTARY PUBLIC

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of ___________________________________ County of ____________________________________

On ______________________, before me, ____
(insert name and title of the office)

Personally appeared ____ , who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity (ies), and by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the state of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

____
Signature of Notary Public

My Commission expires: ________________________

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS
4160 Dublin Blvd, Suite 400 * Dublin, CA 94568
Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301
www.Local39Benefits.org * l39pension@hsba.com

STATEMENT OF APPLICATION RECEIPT

(**Married participants ONLY**)

In order to comply with Federal Regulations related to the 30-day waiver form (enclosed with this application), the Fund Office must have a statement from you indicating the date you received an explanation of your benefit options.

Please indicate the date you received this application packet: ___________________________________

Participant Signature: ____

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568
Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301
www.Local39Benefits.org * l39pension@hsba.com

RETIREMENT DECLARATION

Upon receiving a pension benefit from the Stationary Engineers Local 39 Pension Plan, I declare that I will be bound by the provisions of the Pension, and that:

I understand that in order to be eligible to receive monthly pension benefits, I must be **"RETIRED"** as defined in Section 9.10 and refrain from Prohibited Employment as defined in Section 1.26 of the Plan.

Section 1.26 Prohibited Employment

Prohibited Employment is employment that meets the following conditions:

(1) It is in the industry. The term "industry" includes any business activity of a type in which employees were employed in Covered Employment at the time that payment of benefits to the Participant commenced if the Participant had not remained in or returned to employment.
(2) It is in a trade or craft in which the Participant was employed at any time in Covered Employment.
(3) It is in the geographic area covered by the Plan, including the State of California.
(4) Prohibited Employment includes employment meeting the above conditions, that is in a supervisory or self-employed capacity.

Section 9.10 Retirement

Before Normal Retirement (age 65): To be deemed retired, I must cease and refrain from work in Prohibited Employment of 500 hours or more during a Plan Year.

After Normal Retirement Age and Before the Required Beginning Date: To be deemed retired, I must cease and refrain from work in Prohibited Employment during a Plan Year which exceeds 39 hours per month. For purposes of this Subsection, the first 500 hours of work in a Plan year shall be disregarded.

Section 1.13 Hours of Work

"Hours of Work" means each hour for which an Employee is paid or entitled to payment by an Employer for performance of duties during the applicable computation period, including hours for which back pay may be awarded or agreed to by an Employer, and for each hour for which an Employee is directly or indirectly paid or entitled to payment on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) because of vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

I understand that if I return to Prohibited Employment as described above after my pension effective date, I will not be entitled to a pension benefit for any calendar month after I have exceeded the hours in which I engage in Prohibited Employment.

I understand that I must notify the Fund Office in writing within **21** days after I start any work of the type described above. I understand that in accordance with the Plan, suspension of pension payments shall not apply for employment in work of the type described in Section 9.10 on or after April 1 following the date I attain age 72.

I understand that if I retire under the Rule of 70 Early Retirement Option I shall not engage in Prohibited Employment as defined in Section 1.26. In the event I do recommence such employment, my pension shall automatically be suspended, and I shall not again be eligible for retirement under the provision of the Rule of 70 Early Retirement and I will only be entitled to retire at the Normal Retirement Age.

I understand that I, personally, must endorse each pension check unless my pension check is sent to my bank for direct deposit. Please confirm your last day of work, sign, and date this declaration and return it in the enclosed self-addressed envelope. No action will be taken to begin your pension payments until your reply is received.

I certify that my last day of work will be/was ____.

Name: ____

Signature: ______________________________________ Date: ________________________

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568
Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301
www.Local39Benefits.org * l39pension@hsba.com

DIRECT DEPOSIT REQUEST

Name: ______________________________ SSN: ____________________

Address: ______________________________ Phone: ____________________

City: ______________________________State: __________ Zip Code: ____________

I, the undersigned, hereby authorize the Board of Trustees of the Stationary Engineers Local 39 ("the Pension Plan") to deposit all amounts due to me under the Pension Plan in my account at the Financial Institution named below. This authorization shall remain in force until I revoke it in writing or until my death, whichever occurs first. If, due to lack of knowledge of my death, the Pension Plan distributes benefit checks after my death for deposit in my account, I authorize and direct the Financial Institution to refund to the Pension Plan any amounts paid after my death.

______________________________ ____________________

Signature **Date**

In order for this request to be processed for the current month, the direct deposit form must be received before the 15th of the month.

The following is to be completed by the Financial Institution

AGREEMENT OF FINANCIAL INSTITUTION

The Financial Institution named below agrees to accept for deposit in the account specified below, benefit checks payable by the Stationary Engineers Local 39 ("the Pension Plan"). The Financial Institution agrees to refund to the Pension Plan, the amount of any pension benefit checks deposited in the Payee's account which represents pension benefits paid after the death of the Payee, provided that the amount of the deposits remain in the account at the time the request for a refund is received from the Pension Plan.

Name of Financial Institution: ____

Can you accept "Automated Clearing House" transactions? Yes ☐ No ☐

Bank ABA No. ____________________ Account No. ____________________

Type of Account: ☐ Checking/Share Draft ☐ Savings

Branch ______________________________ Phone ____________________

Address ____

City ______________________________ State __________ Zip Code __________

______________________________ ______________ ______________

Signature of Authorized Representative Title Date

STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

4160 Dublin Blvd, Suite 400 * Dublin, CA 94568
Phone: (925) 208-2280 * Toll Free: (800) 622-0547 * Fax: (925) 833-7301
www.Local39Benefits.org * l39pension@hsba.com

State Tax Withholding Election

ONLY FOR RESIDENTS OF CALIFORNIA, OREGON, OR NEW MEXICO

Name ____ SSN _________________________

Address ____

City ____ State ____________ Zip Code ______________

Please elect **one** of the options below:

(__) I do not want any state income tax withholding.

(__) I want state income tax withholding as indicated below:

Marital Status: ❑ Single ❑ Married ❑ Married, but withhold at Single Rate

Number of exemptions claimed: _______________

(__) Please withhold state income tax in the amount of $ ___________________ per month

Signature: ____ Date: ____________________