

U. A. LOCAL 350 RETIREMENT TRUST
P. O. BOX 1037 SPARKS, NEVADA 89432
APPLICATION FOR WITHDRAWAL OF ACCUMULATED SHARE

INSTRUCTIONS:

1. Please read each question carefully.
2. Print all information.
3. Be sure to answer all applicable questions to the best of your ability.
4. Be sure to sign and date the application.
5. Provide proof of your age.

PERSONAL DATA:

Name _____
Last First Middle

Social Security Number _____ Phone No. _____

Address _____
Street Apt.

_____ City State Zip

Date of Birth _____ Local Union No. _____
(please attach proof of age)

MARITAL STATUS:

Single

Married (Please attach a copy of your marriage certificate)
Spouse's Name _____
Spouse's Date of Birth _____
Month/Day/Year

Spouse's Social Security No. _____

Widowed

Legally Separated

Divorced

Have your pension benefits under this plan been assigned to a spouse, child or other...
person under any court order related to the dissolution of marriage or relating to child
support payments?

Yes [] No []

Is there any pending dissolution, separation or child support proceeding?

Yes [] No []

If Yes, to either of the above, please attach a copy of any such order or summarize the status of any pending proceedings.

WORK HISTORY WITHIN JURISDICTION OF LOCAL 350:

Date you last worked or will work in Covered Employment _____

Name of Last Employer _____

Date you Retired or Plan to Retire _____

RETIREMENT DATA:

Check the statement below that applies to you. Your benefits cannot be calculated without this information.

1. ___ I have been terminated from Covered Employment (did not resign or leave on my own initiative) as a result of the impacts of COVID-19. I understand I shall be entitled to a distribution of up to 50% of the balance in my individual account up to a maximum gross distribution of \$20,000 based on the most recent valuation as determined by the Fund Manager. I understand that a distribution is permitted under this provision only once through June 30, 2020.

EARNINGS:

1. I acknowledge no earnings are allocated to my Individual Account if I receive a distribution in-between the quarterly valuation dates.

PAYMENT OPTIONS:

1. A life annuity issued under an insured group annuity contract which the Trustees may arrange through an insurance company.

2. A Qualified Joint and Survivor Annuity with a 50% lifetime continuation to my surviving Spouse issued under an insured group annuity contract which the Trustees may arrange with an insurance company.

3. A lump sum payment.

FOR ALL APPLICANTS

I understand that the falsity of any statement material to this application or the furnishing of fraudulent information or proof shall be sufficient reason for the denial, suspension or discontinuance of benefits under the Annuity Plan, and the Board of Trustees has the right to recover any benefit payments made in reliance thereon. I further understand that if I disagree with any action taken on this application, I may request a review of such action by the Board in accordance with Section 4 of the Plan.

Signature

Date

U.A. LOCAL 350 RETIREMENT TRUST
EARLY RETIREMENT DECLARATION

Name

Social Security Number

In retiring from the U.A. Local 350 Retirement Trust, I declare that I will be bound by all of the provisions of the Retirement Trust and that:

I understand that the term "Retirement" shall mean the complete withdrawal from any employment or self-employment that is within the collective bargaining agreement jurisdiction of the Union and regardless of whether a collective bargaining agreement actually exists with respect to the employment or self-employment involved.

I understand that in order to be entitled to a withdrawal before attaining age 62, I must refrain from working in the plumbing and pipefitting industry in the geographic area under the jurisdiction of U.A. Local Union No. 350.

I hereby certify under penalty of perjury that I am not engaged in such work and have no plans to engage in such work.

Signature

Date

Notary Public

or

Trust Fund Representative

U.A. LOCAL 350 RETIREMENT TRUST

Employee's Statement

I, _____, do not wish to receive my annuity benefits in the form of a Joint and Survivor Annuity. I understand that by rejecting this form of annuity, no benefits will be paid to my spouse by the retirement Plan after my death, unless death benefits are payable under another option that I select.

I certify the following to be true:

_____ I hereby swear that I am not legally married at this time.

_____ I hereby swear that I am unable to locate my spouse.
(Additional proof is needed if you check this box).

_____ I hereby swear that the person signing the spousal statement is my current legal spouse.

Employee's Signature

Trust Fund Representative

Social Security Number

Date

State of _____

County of _____

On the _____ day of _____ 20_____ before me personally appeared

personally known to me – or –

proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to within the instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

Signature of Notary

U.A. LOCAL 350 RETIREMENT TRUST

SPOUSAL CONSENT STATEMENT

I, _____, swear that I am the legal spouse of the employee described on the Employee's Statement. I hereby consent to my spouse's rejection of the Joint and Survivor Annuity from the U.A. Local 350 Retirement Trust. I understand that as a result of this election and my consent to it, I will not be paid a benefit from the Retirement Plan after my spouse's death, unless death benefits are payable to me under another option that my spouse elects.

Signature of Spouse

Fund Office Representative

Spouse's Social Security No.

Date

State of _____

County of _____

On the _____ day of _____ 20 ____ before me personally appeared

- personally known to me -or-
- proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal.

** _____
Signature of Notary

**Not necessary if witnessed by a Fund Office Representative.

U.A. LOCAL 350 RETIREMENT TRUST
ROLLOVER ELECTION FORM

ATTENTION: BEFORE COMPLETING THIS FORM YOU SHOULD READ THE
SPECIAL TAX NOTICE REGARDING PLAN PAYMENTS
CAREFULLY. YOU ALSO MAY WISH TO CONSULT YOUR
TAX ADVISOR BEFORE MAKING THIS ELECTION.

Complete this form only if you will receive a payout in a lump sum, a series of payments for a scheduled period of less than 10 years, or other eligible rollover distribution.

Participant's Name or Beneficiary's Name	Social Security Number	
Street Address	Apt. No.	
City	State	Zip Code

If you receive part or all of your benefits as an "eligible rollover distribution", you may elect to have part or all of that distribution transferred directly to an Individual Retirement Account (IRA) or to another qualified retirement plan (if it accepts rollovers). If you choose not to have an eligible rollover distribution transferred directly to an IRA or other retirement plan, the Plan is required to withhold 20 percent of the payment for federal income taxes. This withholding does not increase your taxes, but will be credited against any income tax you owe. (For further information on direct rollovers and withholding, please read the Special Notice Regarding Plan Payments that the Plan has given you.)

CHECK AND INITIAL below to indicate whether or not you elect a direct rollover of your pension payment:

I do not want to rollover any of my payment to an IRA or other qualified retirement plan. Pay me the full amount of my benefits, after withholding 20 percent for federal income taxes as required by law.

I acknowledge in accordance with the Tax Reform Act of 1986, there is potential 10% tax on certain early distributions. (see attached tax notice)

YES I would like the additional 10% withheld from my distribution.

NO I would not like the additional 10% withheld from my distribution.

I want to rollover my payment directly to an IRA or other qualified retirement plan that accepts rollovers. The IRA or other retirement plan is named below.

I would like to have only part of my payment directly rolled over. Please rollover \$ _____ to the IRA or qualified retirement plan named below, and pay the remainder of my benefit to me, after withholding 20 percent for federal income taxes as required by law.

If you elected a direct rollover, you must provide all of the following information. Until you provide this information, no direct rollover can be made.

Please make payment of my benefits on my behalf to:

Name of IRA Trustee or Qualified Retirement Plan

Account Number

Mailing Address

CERTIFICATION

If you have elected a direct rollover of all or part of your benefit, please read and sign the following statement:

I certify that the recipient of a direct rollover that I have named above is an Individual Retirement Account, an Individual Retirement Annuity, or a qualified retirement plan that accepts rollovers. I understand that payment of my benefits to the trustee of the IRA or qualified retirement plan will release the Trustees of the U.A. Local 350 Retirement Trust from any further obligations or responsibilities with respect to the benefits so paid.

Signature

Date

U.A. LOCAL 350 RETIREMENT TRUST

Name

Social Security Number

CONSENT FOR EARLY RELEASE OF BENEFITS

I understand that under the federal pension law known as ERISA, I have at least a 30-day period to consider my benefit election and options available under the U.A. Local 350 Retirement Plan. I also understand that if I complete and return this form before the end of that 30-day period, I have relinquished my right to consider my benefit election for the full 30-day period.

I recognize that even if I complete and return this form before the end of the 30-day period, I may still revoke and remake my benefit election as often as I wish until I actually receive a benefit payment.

I understand that my Plan benefits may not be paid or begin to be paid any earlier than the eighth (8th) day after the date I sign this form. Accordingly, I hereby (chose one):

- WAIVE MY RIGHT TO CONSIDER MY BENEFIT ELECTION FOR THE FULL 30-DAY PERIOD DESCRIBED ABOVE, AND INSTEAD, I HEREBY ELECT TO HAVE MY PLAN BENEFITS PAID OR TO BE PAID, IN ACCORDANCE WITH MY ELECTION, AS SOON AS POSSIBLE.
- DO NOT WAIVE MY RIGHT TO CONSIDER MY BENEFIT ELECTION FOR THE FULL 30-DAY PERIOD DESCRIBED ABOVE. THUS, THE BENEFIT ELECTION THAT I HAVE MADE ON THIS FORM MAY NOT BE CARRIED OUT UNTIL AT LEAST 30-DAYS HAVE ELAPSED FROM THE DATE I RECEIVE THIS FORM.

Signature of Participant

Date

Signature of Spouse

Date

Notary or Trust Fund Representative

INSTRUCTIONS CONCERNING SUBMISSION OF PROOFS OF AGE

Proof of your age will be required before any pension benefit can be permitted. The acceptable proofs of age are listed below in two groups. Submit a photocopy of *one* of the proofs listed in GROUP I, if you have it, or can possibly obtain it, since this class of proof of age is more convincing.

If you cannot submit a proof in GROUP I classification, submit photocopies of *two* (2) of the proofs listed in GROUP II, and the Board of Trustees retains the right to request additional items. You are cautioned, however, that Naturalization Papers, United States Passports and Immigration Papers may **not** be photocopied. If you are submitting any of these, you must submit the original. All original documents will be returned to you.

GROUP I

1. A birth certificate.
2. A baptismal certificate or statement as to the date of birth shown by the custodian of such record.
3. Notification of registration of birth in a public registry of vital statistics.
4. Certification of records of age by the United States Census Bureau.
5. Hospital birth record, certified by the custodian of such record.
6. A foreign church or government record.
7. A signed statement by the Physician or midwife who was in attendance at the birth, as to the date of birth shown on their records.
8. Naturalization Papers (Submit Original).
9. Immigration Papers (Submit Original).

GROUP II

1. Military Records.
2. Passport (Submit Original).
3. School records, certified by the custodian of such records.
4. Vaccination records, certified by the custodian of such records.
5. An insurance policy at least five (5) years old which shows age or date of birth.
6. Marriage records showing date of birth or age (application for marriage license or church record, certified by the custodian of such records; or marriage certificate).
7. Other evidence such as signed, notarized statements from persons who have knowledge of the date of your birth.

U.A. LOCAL 350 RETIREMENT TRUST
445 APPLE STREET, PO BOX 11337, RENO, NV 89510-1337

Participant's Name	Social Security Number		
Street Address	Apt No.		
City	State	Zip	

The participant named above is unemployed on March 16, 2020 or after and has involuntarily been terminated from Covered Employment and has not performed any employment in the Plumbing and Pipe Trades Industry for thirty consecutive calendar days as a result of the impacts of COVID-19.

Chris Doris Financial Secretary	Date
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**U.A. LOCAL 350 RETIREMENT TRUST PLAN
INVESTMENT ELECTION FORM**

Return to: 445 Apple Street, Suite 109, Reno, Nevada 89502 (775) 826-7200 Fax: (775) 824-5080

PARTICIPANT INFORMATION

Name _____ Social Security # _____ Date of Birth _____

Address _____

DISTRIBUTION ELECTION

PLEASE INDICATE THE AMOUNT AND THE FUND FROM WHICH THE DISTRIBUTION SHOULD BE ALLOCATED FOR YOUR PARTIAL DISTRIBUTION.

	From
Champlain Mid Cap Fund	\$ _____
Dodge & Cox Stock (Large Value Stock)	_____
Vanguard 500 Index (Large Blend Stock)	_____
Vanguard STAR (Balanced Fund)	_____
Morley Stable Value Fund	_____
Dodge & Cox International Fund	_____
Vanguard REIT Index Fund	_____
Vanguard Total Bond Market Index Fund	_____
Growth Fund of America	_____
American Beacon Small Cap Value Fund	_____
Dodge & Cox Income Fund	_____
Total	\$ _____

I understand taxes will be deducted from the above amount.

Participant's Signature _____ Date _____