BOSTON PLASTERERS' & CEMENT MASONS' LOCAL #534
SUPPLEMENTAL UNEMPLOYMENT BENEFIT PLAN II

APPLICATION FOR DISABILITY, DEATH, OR MEDICAL BENEFITS

In accordance with the above Plan, I hereby apply for benefits.

NAME(please print) _____ S.S. #_____/____/_____
Last First Initial

ADDRESS _____
No. Street City State Zip

DATE OF BIRTH_____/_____/_____ TELEPHONE # _____
Month Day Year

DATE OF MEMBERSHIP IN LOCAL UNION _____

DATE OF EMPLOYMENT IN INDUSTRY _____

FOR DISABILITY BENEFITS

DATE AND DETAILS OF DISABILITY: (Use additional space if necessary)

_____

_____

_____ Amount $_____

(Employee *must* attach a certificate from a Physician outlining details of such disability.)

FOR DEATH BENEFITS

(To be completed by Beneficiary)

DATE OF DEATH OF MEMBER_____ DATE OF BIRTH OF BENEFICIARY_____

NAME OF BENEFICIARY_____ S.S. #_____/____/_____

ADDRESS_____
No. Street City State Zip

FOR MEDICAL BENEFITS

***** Attention LOCAL 534 members *** Please be sure you are requesting reimbursement from your HRA (Health Reimbursement Arrangement) if you are eligible and have available monies prior to requesting reimbursement from the SUB Fund.**
(Please include a copy of PAID medical bills for which you are requesting reimbursement)

Details for reason for claim:

_____

_____

_____Amount $_____

OVER-→

I authorize the Trustees, or their representatives to contact any person, organization or corporation and authorize such person, organization or corporation to release all information concerning my application. Also, I am not currently receiving workers' compensation benefits.

I understand that this payment will be reported to the Federal and State Tax Authorities and may constitute a distribution taxable under both Federal and State Regulations. The Plan withholds, from your benefit, 20% for Federal and 5% for State tax. To the extent funds withheld are not sufficient for tax purposes, I agree to be responsible for any further taxes that may be due. You may want to consult your tax advisor regarding your particular circumstances.

_____ _____

Witness Signature

_____

Date

This form together with all attachment should be forwarded to: Benefits Office SUB Fund
Boston Plasterers' & Cement Masons' Local 534
7 Frederika Street
Boston, MA 02124

TO BE COMPLETED BY THE ADMINISTRATOR

Administrator Signature_____

Date _____