PLUMBERS AND PIPEFITTERS LOCAL 501
NORTHERN ILLINOIS BENEFIT FUNDS

1295 Butterfield Rd., Aurora, IL 60502-8879 • Ph (630) 978-4600 • Fax (630) 978-4616 • email: benefitfunds@ualocal501.org

DISABILITY PENSION BENEFIT

PROCEDURES

The Northern Illinois Pension Fund provides for a disability pension benefit for individuals who have at least 10 years of vested service and become totally and permanently disabled from "engaging in any regular construction occupation or employment as a result of a physical or mental condition of the Participant" and who have earned at least one year of vested service in either of the two plan years immediately preceding the date of the total disability. If the applicant has not been approved for a Social Security Disability award, the Board of Trustees of the Northern Illinois Pension Fund have established a policy whereby applicants for a disability pension must participate in an independent medical exam ordered by the Plan Administrator. This process involves an independent physician examining the applicant and determining if the applicant is totally and permanently disabled from "engaging in any regular construction occupation or employment as a result of a physical or mental condition of the Participant".

The Trustees want to impress upon you that this process sometimes can take up to 6 months or more before an actual determination is made. At times, the examining physician may require the patient/applicant to go through a functional capacity evaluation or a work hardening program to determine whether the applicant is in fact totally and permanently disabled.

In some cases, you may be receiving benefits through a worker's compensation insurance program and this may help the applicant through some difficult times. In other instances, if the illness or injury is not work related, the applicant might be receiving loss of time benefits from the Benefit Fund currently at $350 per week, for up to 6 months. A Disability Pension Benefit cannot be paid to the applicant if there is an on-going worker's compensation case or if loss of time is being paid to the applicant.

The Board of Trustees reviews each application for a Disability Pension Benefit. The Board meets every other month to review other issues as well. Once approved, the Trustees have an obligation to also follow up with reviews to determine if the applicant continues to be disabled. The Trustees may also ask for copies of tax filings and confirmation from a physician that the recipient is still disabled.

This process insures that only those individuals who are totally and permanently disabled receive a Disability Pension Benefit.

62 will be waived for the portion of your benefit that you earned after you re-entered covered employment.

Payment of your monthly pension will be made in one of the methods described in the "Forms of Payment" section.

DISABILITY PENSION

You are eligible for a disability benefit from the Plan if you become permanently and totally disabled after you have completed ten or more years of vested service and you have earned at least one year of vested service in either of the two plan years preceding your disability. However, no disability benefit will be paid during the period you receive a disability benefit under any other program to which a contributing employer contributes.

A person who was a prior participant in the former Local 554 or Local 612 plans who first became a participant in this Plan on June 1, 1998 will be eligible for a disability pension if the participant:

- Terminates employment on or after May 7, 2002 as a result of a total disability; and
- Has completed at least five years of vested service under this Plan after June 1, 1998, at least one of which was completed during the two plan years immediately preceding the date his total disability began.

"Permanently and totally disabled" means a mental or physical condition that permanently and totally prevents you from engaging in any regular construction occupation or employment and is expected to be permanent and continuous for the rest of your life. However, total disability does not include disability resulting from:

- Criminal activity;
- Self-addiction to illegal substances;
- Participation in any U.S. military service; or
- Participation in a declared or undeclared war, riot or state of civil unrest.

Your disability benefit will equal your full basic pension benefit, based on your frozen accrued benefit and the creditable contributions which have been made for you between June 1, 1998 and the date you terminate employment. Your monthly benefit will start on the first day of the month following your termination of employment if you have applied for a disability pension.

Your benefits will stop if any one of the following occurs:

1. You take another job for profit in excess of $500 per month;
2. The Plan Administrator determines on the basis of any medical exam that you no longer have a total disability;
3. You begin receiving a disability benefit under another program to which a contributing employer contributes;
4. You refuse a medical examination requested by the Plan Administrator;
5. You attain age 62; or
6. You die.

If you attain age 62 while receiving a disability benefit, you will become eligible to receive a normal retirement benefit in any form of payment available under the "Forms of Payment" section. If you die while receiving a disability benefit, your spouse or beneficiary will become eligible to receive the death benefit set forth in the "Pre-Retirement Death Benefits" section.

NORTHERN ILLINOIS PENSION FUND
APPLICATION FOR BENEFITS

Name _____
First Middle Last Date of Birth Social Security Number

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

I hereby apply under the above named retirement plan for the following type of benefit to become effective on:

_____
Month Day Year

Check One:

☐ Normal Retirement Benefit ☐ Disability Benefit

☐ Early Retirement Benefit ☐ Survivor Benefit (date of participant's death ____/___/____)

☐ Late Retirement Benefit

Have you been divorced since 1984? Yes☐ No☐ If yes how many?____
If yes, a copy of the divorce decree(s) is required
Are you aware of an existing Qualified Domestic Relations Order(s)? Yes☐ No☐
If yes, a copy of the Qualified Domestic Relations Order (QDRO) is required

If this is a disability application was it work related?	Yes☐	No☐
Is there a worker's compensation claim?	Yes☐	No☐
Are you receiving worker's compensation benefits?	Yes☐	No☐
Have you applied for Social Security Disability?	Yes☐	No☐
If yes a copy of the application is required		
Were Social Security Benefits	Approved ☐	Denied ☐
Copy of the award/determination is required.		

While you were a member of the Local were you in the Military? Yes☐ No☐
If yes when

This application is subject to review and approval by the Northern Illinois Pension Fund Board of Trustees. I understand that the Plan Administrator's acceptance of this application is in no way a determination that I am entitled to receive a pension and that my eligibility will be determined in accordance with the plan document

_____ _____
Signature Date

Witnessed by:

_____ _____
Plan Representative or Notary Public's Signature Date

Date Received by Plan Administrator: _____

APPLICATION FOR NORTHERN ILLINOIS PENSION FUND FOR TOTAL AND PERMANENT DISABILITY PENSION BENEFITS

STATEMENT OF APPLICANT

1. Name:_____

2. Address:_____

3. Date of Birth:_____ Occupation:_____ SS#_____

4. Name and address of last employer:_____

5. Nature of present sickness or injury:_____

6. On what date were you first totally disabled by this sickness or injury?_____

7. On what date did you stop work?_____

8. Have you engaged in any occupation or business since the beginning of this disability? If so, give particulars:_____

9. On what date were you first treated by a physician for this disability?_____

10. Physicians whom you consulted during present illness or injury:

Name	Address	Period Treated
Dr._____	_____	From_____ to _____
Dr._____	_____	From_____to_____
Dr._____	_____	From_____to_____

11. Hospitals and dispensaries where you were treated during present illness:

Name	Address	Period Treated
_____	_____	From_____to_____
_____	_____	From_____to_____

12. As a result of this disability, did you receive Loss of Time benefits from the Northern Illinois Benefit Fund? Yes ☐ No ☐

13. Have you been retired by the City, State, Federal Government or other employer for disability?

If so, give date:_____

Date_____, 20____ _____
Signature of Applicant or Representative

Date_____,20____ (OVER) By_____

Notary Signature_____ (Affix Notary Stamp or Seal here)

Return Completed Form to: Northern Illinois Pension Fund – 1295 Butterfield Rd. – Aurora, IL 60504-8879
Ph: (630) 978-4600 Fx: (630) 978-4616

(PRINT)
Name of Patient _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY – Attach separate sheet if necessary to verify extent of disability.

1. HISTORY
   (a) When did symptoms first appear or accident happen? Mo._____ Day_____ 20_____
   (b) Date patient ceased work because of disability. Mo._____ Day_____ 20_____
   (c) Has patient ever had same or similar condition? Yes ☐ No ☐
   If yes, state when and describe.

2. PRESENT CONDITION
   (a) Subjective symptoms
   (b) Objective findings (Include results of current X-rays, E.K.G.'s, or any other special tests).
   (c) Is patient..... Ambulatory? ☐ Bed confined? ☐ House confined? ☐ Hospital confined? ☐

3. DIAGNOSIS

4. TREATMENT
   (a) Date of first visit..... Mo._____ Day_____ 20_____
   Date of last visit..... Mo._____ Day_____ 20_____
   Frequency of visits..... Weekly ☐ Monthly ☐ Other ☐
   (b) When did you last examine the patient? Mo._____ Day_____ 20_____

5. PROGRESS Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

6. EXTENT OF DISABILITY

	FOR ANY OCCUPATION	FOR HIS REGULAR OCCUPATION
(a) Is patient now totally disabled?	Yes ☐ No ☐	Yes ☐ No ☐
(b) If no, when was patient able to go to work?	Mo._____ Day_____ 20_____	Mo._____ Day_____ 20_____
(c) If yes, when do you think patient will be able to resume any work?		
Approximate Date.....	Mo._____ Day_____ 20_____	Mo._____ Day_____ 20_____
Indefinite.....	☐	☐
Never.....	☐	☐

(d) If yes, is patient a suitable candidate for a rehabilitation program? Yes ☐ No ☐

7. MENTAL CONDITION
   Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes ☐ No ☐

Complete appropriate section, if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

8. CARDIAC
   (a) Functional capacity (American Heart Ass'n)..... Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation ☐ Class 4 (Complete limitation) ☐
   (b) Blood Pressure.....

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE (OR PROVINCE)	ZIP CODE

NORTHERN ILLINOIS PENSION / RETIREMENT FUND
STATEMENT OF NON-WORK

NAME: _____

SS#: _____

Northern Illinois Pension/Retirement Fund
1295 Butterfield Road; Aurora, IL 60502-8879

PH: (630) 978-4600 FX: (630) 978-4616

Employer Statement:
This is to certify that _____ a former employee of _____has in fact, terminated his/her employment effective _____ that all compensation due him/her has been paid including accrued vacation or sick leave, if any and there is not a workers compensation case pending.

_____ _____
Employer Representative Signature **Date**

_____
Please Print Name and Title

Employee Statement:
I am no longer working or self-employed as a Plumber or Pipefitter in the construction industry in the geographic jurisdiction of Local 501 and request that my application be considered for approval.

LAST MONTH, DAY AND YEAR WORKED:_____

FOR:_____

I understand the Trustees shall suspend the pension benefits of any retiree during certain periods of reemployment. Benefits shall be suspended if the retiree is paid for 40 or more hours in a calendar month in:

- **An industry in which employees were employed and earned benefits under the Plan at the time the Participant's pension benefits commenced or would have commenced if the Participant had not remained in or returned to employment;**
- **A trade or craft in which the Participant was employed at any time under the Plan; and**
- **The geographic area covered by the Plan at the time the payment of benefits commenced or would have commenced if the Participant had not remained in or returned to employment.**

_____ _____
Employee's Signature **Date**

Witnessed by:

_____ _____
Plan Representative or Notary Public's Signature Date

On this _____ day of _____, 200__ before me came _____ to me know to be the individual who did in my presence execute the foregoing Statement of Non-Work.

_____ My Commission Expires:_____
Notary Public Seal/Stamp

RE: QUALIFIED DOMESTIC RELATIONS ORDER (QDRO)
NORTHERN ILLINOIS PENSION FUND
NORTHERN ILLINOIS RETIREMENT FUND

Dear Pension and Retirement Fund Participant:

Since 1984, a spouse may claim a part of a beneficiary's pension as part of a settlement agreement in a dissolution of marriage. This claim must be brought by submitting a QDRO (Qualified Domestic Relations Order), signed by a Court of competent jurisdiction and submitted to the Fund. The document is not valid unless it is received and accepted by the Fund and the Fund is, therefore, required to provide a receipt (an acknowledgement that the QDRO is acceptable). In order to make sure that our records are correct, we require that you complete the questionnaire at the end of this correspondence.

If you were married and have been divorced since 1984, you must provide the Fund office with a copy of the divorce decree, if there was no agreement for your spouse to share your pension, (defined benefit or defined contribution plan). If there was an agreement for your prior spouse to share your pension, you must provide this office with a QDRO, if you have not already done so.

NAME:_____ SS#_____

ADDRESS:_____ PHONE #_____

CITY:_____ STATE:_____ ZIP:_____

☐ I have been divorced since 1984.
If so, Date of Divorce_____, County_____,
State_____.

☐ I have enclosed a copy of the final divorce decree.

☐ I have enclosed a copy of the QDRO(s).

☐ I have **NOT** been divorced since 1984.

_____ _____
Signature Date