# SHEET METAL WORKERS'
# LOCAL UNION NO. 28 FUNDS AND PLANS
# METROPOLITAN NEW YORK AND LONG ISLAND



May 4, 2022

Dear Member,

The Local 28 funds office has noticed that either you do not have any beneficiaries on file, or it has been sometime since your beneficiaries have been updated. Included are beneficiary forms for you to fill out, sign, date and return to the Funds office at the address below. We have also enclosed a Coordination of Benefits form that must be filled out, signed, dated, and returned.

You can also find the forms on the Union's website www.smart28.org and clicking on the Union Fusion Portal.

Sincerely,

The Board of Trustees
Sheet Metal Workers Local Union 28

195 MINEOLA BOULEVARD • MINEOLA, NEW YORK 11501
TEL: (516) 742-9478 • FAX: (516) 742-6360

# SHEET METAL WORKERS LOCAL UNION 28

BUILDING TRADES / PRODUCTION WORKERS ***(Circle One)***

195 Mineola Blvd, Mineola NY 11501

(516) 742-9478

| **I)** | ***MEMBER'S INFORMATION*** | |
|---|---|---|
| SOCIAL SECURITY NUMBER: | | I.A. NO: |
| LAST NAME | FIRST NAME: | MIDDLE NAME: |
| DATE OF BIRTH: | SEX: _____ | (M) Male (F) Female |
| ADDRESS | | APT NO.: |
| CITY | STATE: | ZIP CODE: |
| PRIMARY PHONE: ( ) - | EMAIL ADDRESS | |
| EMPLOYER'S NAME | | DATE OF HIRE: |
| MARITAL STATUS_____(M) Married, (S) Single, (D) Divorced, (L) Legally Separated | | |

| **II)** | ***DEATH BENEFIT BENEFICIARIES*** | |
|---|---|---|
| (YOU MAY ATTACH A SEPARATE PAGE IF MORE THAN TWO BENEFICIARIES NEED TO BE LISTED) | | |
| 1. BENEFICIARY'S LAST NAME: | BENEFICIARY'S FIRST NAME: | |
| BENEFICIARY'S FULL SSN: | RELATIONSHIP: | |
| BENEFICIARY'S DATE OF BIRTH | (P) Primary - (S) Secondary _____ | Percentage: _____ |
| BENEFICIARY'S ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |
| 2. BENEFICIARY'S LAST NAME: | BENEFICIARY'S FIRST NAME: | |
| BENEFICIARY'S FULL SSN: | RELATIONSHIP: | |
| BENEFICIARY'S DATE OF BIRTH | (P) Primary - (S) Secondary _____ | Percentage: _____ |
| BENEFICIARY'S ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |

**III)** ***MEDICAL BENEFITS: DEPENDENT COVERAGE***

LIST YOUR DEPENDENTS (Spouse; Children up to age 26)

| LAST NAME | FIRST NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH | | | SEX | | RELATIONSHIP |
|---|---|---|---|---|---|---|---|---|
| | | | MONTH | DATE | YEAR | MALE | FEMALE | (SPOUSE, SON, OR DAUGHTER) |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

*******Note: Dependent(s) will not be added to your coverage until a marriage or birth certificate is submitted to our office*******

***D) SIGNATURE:*** _____ ***DATE:*** _____

# SHEET METAL WORKERS' LOCAL UNION NO. 28 PENSION FUND METROPOLITAN NEW YORK AND LONG ISLAND

## PRE-RETIREMENT BENEFICIARY DESIGNATION FORM

NOTE: If you wish to name more than two Primary and/or Secondary Beneficiaries, please attach a separate sheet of paper with your additional designations. You must also sign and date the additional sheet of paper. If you are married and designate any Primary Beneficiaries who are not your spouse, you must obtain your spouse's written and notarized consent on the reverse of this form.

**Return the completed form to the Fund Office:**

### I. PARTICIPANT'S INFORMATION

First Name _____ MI ____ Last Name _____ Social Security Number _____

**CHECK ONE: ____Initial Beneficiary Designation ____Change In Prior Beneficiary Designation**

**MARITAL STATUS: ____Married ____Not Married**

### II. PRIMARY BENEFICIARY DESIGNATION

If I am married and have not designated my spouse as my sole Primary Beneficiary, this designation of beneficiary will not be effective unless consented to by my spouse on the other side of this form. If I am not married on the date I sign this Beneficiary Designation Form, but subsequently become married, I understand that this designation of beneficiary shall cease to be effective upon my marriage. I hereby agree to notify the Plan Administrator in writing in the event my marital status changes.

I hereby designate as my Primary Beneficiary the person or persons listed below who survive me. If more than one person is listed, benefits shall be divided according to the percentages indicated. I understand that if I designate more than one beneficiary below, the percentages must add up to 100%. If more than one person is listed and no percentages are indicated, benefits shall be paid in equal shares to my primary beneficiary(ies) who survive me. If a percentage is indicated and a Primary Beneficiary(ies) does not survive me, the percentage of that beneficiary's share shall be divided among the surviving Primary Beneficiary(ies) in proportion to the percentages shown for such beneficiary(ies) below.

Name _____ Date of Birth _____ Social Security Number _____ Percentage _____

Relationship _____ Address _____

Name _____ Date of Birth _____ Social Security Number _____ Percentage _____

Relationship _____ Address _____

### III. SECONDARY BENEFICIARY DESIGNATION

If no Primary Beneficiary listed in Part I above survives me, I hereby designate as my Secondary Beneficiary the person or persons listed below who survive me. I understand that if I designate more than one Secondary Beneficiary below, the percentages must add up to 100%. Payment to Secondary Beneficiaries will be made according to the rules of succession described for Primary Beneficiary.

Name _____ Date of Birth _____ Social Security Number _____ Percentage _____

Relationship _____ Address _____

Name _____ Date of Birth _____ Social Security Number _____ Percentage _____

Relationship _____ Address _____

### IV. SIGNATURE SECTION

I Understand that distribution of benefits to my designated beneficiary or beneficiaries shall be made in accordance with the terms of the Plan. I also understand that this beneficiary designation supersedes any beneficiary designation currently in effect.

Member's Signature _____ Date _____

195 MINEOLA BOULEVARD • MINEOLA, NEW YORK 11501
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# SHEET METAL WORKERS' LOCAL UNION NO. 28 FUNDS AND PLANS METROPOLITAN NEW YORK AND LONG ISLAND

## PRE-RETIREMENT SPOUSAL SURVIVOR'S BENEFITS WAIVER FORM

**FOR MARRIED PARTICIPANTS ONLY**

**NOTE:** The purpose of this Form is to permit vested Members and their spouses to waive the Spousal Survivor's Benefit that is otherwise payable under Section 5.03 of the Plan upon a Member's death. If a Member waives the Spousal Survivor's Benefit and his or her spouse consents to the waiver by executing this Form, any survivor benefits due and payable following the Member's death will be paid to the beneficiary or beneficiaries selected by the Member on the Beneficiary Designation Form. A Member may only waive the Spousal Survivor's Benefit beginning after the first day of the year in which the Member attains age 35.

**Please complete the following information (type or print) and return to the Fund Office.**

### I. PARTICIPANT STATEMENT

I understand that if I have earned a vested pension under the Plan and die prior to commencement of my pension, my surviving spouse will be paid a lifetime monthly benefit equal to 50% of the monthly benefit I would have received from the Local 28 Pension Fund had I retired the day before I died or, if I died before I was eligible to retire, the monthly benefit I would have received had I left covered employment and retired on the earliest date I would have been eligible (the "Spousal Survivor's Benefit"). If I die before the pension is payable, my spouse will have to wait until I would have been eligible to commence payments.

I further understand that I may waive the Spousal Survivor's Benefit with my spouse's written consent and elect, instead, to have a survivor's benefit of 60 monthly payments paid to the beneficiary or beneficiaries I designated on the Beneficiary Designation Form (which may include my spouse).

I hereby swear that the person co-signing this Form in Section II is my spouse.

I hereby waive the Spousal Survivor's Benefit that would otherwise be payable by the Fund at my death. I understand that this waiver will not be effective without the written, notarized or witnessed consent of the person to whom I am married when I die, and that I can revoke this waiver at any time before my death or retirement.

_____ _____ _____ _____
Member's Name MI Last Name Social Security Number

_____ Signed on _____, 20___ in the presence of _____
Member's Signature Notary Public or Plan Administrator

### II. SPOUSE STATEMENT OF CONSENT

I, _____, swear that I am the legal spouse of _____. I hereby consent to my spouse's waiver of the Spousal Survivor's Benefit from the Local 28 Pension Fund, which is a monthly annuity for my life equal to 50% of the monthly benefit my spouse would have received if my spouse had retired on the day immediately preceding his or her death (if eligible) and commenced his or her benefit payable as a Qualified Joint and Survivor Annuity, or, if my spouse was not yet eligible to retire, the monthly benefit my spouse would have received had my spouse left covered employment and retired on the earliest day my spouse would have been eligible and commenced his or her benefit payable as a Qualified Joint and Survivor Annuity. I understand that as a result of my consent, I will not be paid the Spousal Survivor's Benefit or any other pre-retirement survivor's benefit from the Local 28 Pension Fund, unless my spouse has designated me as his or her beneficiary on the Beneficiary Designation Form.

I have reviewed the Beneficiary Designation Form and agree to let my spouse designate the beneficiary(ies) named on that form. My spouse may withdraw his or her designation at any time, but may not designate a different beneficiary(ies) without my consent.

I understand that I do not have to sign this consent. I am signing this Form voluntarily. I further understand that if I do not sign this consent, I will be entitled to receive any benefit payable under the Plan as a result of my spouse's death.

_____ _____ _____ _____
Member's Name MI Last Name Social Security Number

_____Signed on _____, 20___ in the presence of _____
Spouse's Signature Notary Public or Plan Administrator

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# SHEET METAL WORKERS'
# LOCAL UNION NO. 28 FUNDS AND PLANS
# METROPOLITAN NEW YORK AND LONG ISLAND

## ***SMW Welfare Fund Coordination of Benefits Form***

In order to update our files and prevent delays in the processing of your claims, we are requesting that the below questionnaire be completed and returned to the Fund Office at the address at the bottom of this form within the next 30 days.

MEMBER'S NAME: _____

MEMBER'S DATE OF BIRTH: _____ MEMBER'S IA#: _____

DEPENDENT(S) NAME/RELATIONSHIP (REL)/DATE OF BIRTH: (LIST ALL)

NAME: _____ REL: _____ DOB: _____

NAME: _____ REL: _____ DOB: _____

NAME: _____ REL: _____ DOB: _____

NAME: _____ REL: _____ DOB: _____

Is your spouse employed? (Circle One): YES NO

If yes, name/address of employer: _____

Is your spouse covered under any employer-sponsored health plan? YES NO

If yes, name/address of carrier: _____

Type of Coverage (Circle all that apply): Medical Dental Vision RX

Does the Plan cover your dependent child(ren)? _____

Effective date of Coverage: _____

Member Signature: _____ Date: _____

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