

Phoenix Painting Industry Trust Funds

HEALTH AND WELFARE

ADMINISTRATIVE OFFICE

PENSION

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DISABILITY RETIREMENT DECLARATION

NAME: _____ **SOCIAL SECURITY NUMBER:** _____

IN RETIRING FROM THE PHOENIX PAINTERS' PENSION TRUST FUND ON A DISABILITY PENSION, I DECLARE THAT I WILL BE BOUND BY ALL THE RULES AND REGULATIONS OF THE PENSION PLAN AND THAT:

1. I UNDERSTAND THAT I MUST WITHDRAW COMPLETELY AND REFRAIN FROM ANY EMPLOYMENT ANYWHERE FOR WAGES OR PROFIT IN THE TYPE OF WORK COVERED BY THE COLLECTIVE BARGAINING AGREEMENT WHILE RECEIVING MY PENSION.
2. IF I RETURN TO THE TYPE OF WORK DESCRIBED ABOVE, I WILL NOTIFY THE TRUSTEES IN WRITING OF THIS FACT WITHIN 21 DAYS AFTER I HAVE RETURNED TO WORK.
3. IF I RECOVER OR LOSE ENTITLEMENT TO MY SOCIAL SECURITY DISABILITY PENSION PRIOR TO AGE 65, I WILL NOTIFY THE TRUSTEES IN WRITING 21 DAYS AFTER I RECEIVE NOTICE FROM THE SOCIAL SECURITY ADMINISTRATION OF THE LOSS.
4. I FURTHER UNDERSTAND THAT IF I FAIL TO GIVE THE NOTICE SPECIFIED ABOVE, I WILL SUFFER THE DISQUALIFICATIONS PROVIDED IN THE PLAN
5. I UNDERSTAND THAT I, PERSONALLY, MUST ENDORSE EACH PENSION CHECK.
6. I UNDERSTAND THAT IF I AM UNDER 65 YEARS OF AGE WHILE RECEIVING MY PENSION, I MUST FURNISH TO THE TRUSTEES BY APRIL 15TH OF EACH YEAR, IF REQUESTED, COPIES OF MY FEDERAL TAX RETURN AND COPIES OF ALL W-2 FORM WHICH WERE ATTACHED. I UNDERSTAND THAT FAILURE TO FURNISH THIS INFORMATION AS REQUIRED MAY RESULT IN THE SUSPENSION OF MY PENSION BENEFIT IN ACCORDANCE WITH THE PROVISIONS OF THE PENSION PLAN.

LAST DAY WORKED IN
COVERED EMPLOYMENT _____ EMPLOYER _____

LAST DAY WORKED IN
ANY EMPLOYMENT _____ EMPLOYER _____

SIGNED: _____ DATE: _____