

TEAMSTERS LOCAL 560 BENEFIT FUNDS

TEAMSTERS BUILDING

Mailing Address
303 Molnar Drive
1ST Floor
Elmwood Park, NJ 07407

Telephone 201-867-3553
Toll Free 866-560-FUND
Facsimile 201-305-8052

Date:

Dear Member,

We are enclosing herewith a pension application and summary plan description booklet. Please complete the application in full and return to this office along with the following:

1. Proof of age for yourself
2. Proof of age for your spouse, if applicable
3. A copy of your marriage certificate, if applicable
4. A recent photograph of yourself, signed on the back (no copies please)

Please note: that all pages of this application are to be signed in designated places including the affidavit of martial status that must be notarized.

Please return immediately whereas benefits will not commence until a completed application is returned.

Should you have any questions or concerns, please feel free to call the office at 1-866-560-FUND.

Very Truly Yours,

Pension Department

TRUCKING EMPLOYEES OF NORTH JERSEY

LOCAL 560

PENSION FUND APPLICATION



Please return to:
Trucking Employees of North Jersey
Teamsters Building, First Floor
303 Molnar Drive
Elmwood Park, NJ 07407

INSTRUCTION TO APPLICANT

In order to be eligible for retirement benefits, you are required to produce proof of your age. The following is a list of the documents, which may serve as proof of your age. Some of these documents are better proof than others. This list is arranged with best type of proof, and going down to less desirable types of documents.

You are required to furnish the best type of proof, which is available. It is recognized, of course, that in many cases a birth certificate may not be available, particularly for those who were born outside of the United States. In that case, you should secure the next best type of proof. Additional proof of age may be required if the document which you submit is not convincing proof.

If you do not have any of the documents shown on the list below, write to the Pension Fund office for guidance about other ways of proving your age.

You do not have to furnish the original of any of these documents; you may submit a photocopy.

- 1. A BIRTH CERTIFICATE**
- 2. A BAPTISMAL CERTIFICATE OR A STATEMENT AS TO THE DATE OF BIRTH SHOWN BY A CHURCH RECORD, CERTIFIED BY THE CUSTODIAN OF SUCH RECORDS.**
- 3. NOTIFICATION OF REGISTRATION OF BIRTH IN A PUBLIC REGISTRY OF VITAL STATISTICS.**
- 4. HOSPITAL BIRTH RECORDS, CERTIFIED BY THE CUSTODIAN OF SUCH RECORDS.**
- 5. DOCUMENT SHOWING APPROVAL OF SOCIAL SECURITY PENSION.**
- 6. PASSPORT**
- 7. MILITARY RECORD**

APPLICATION FOR PENSION BENEFITS

Please read carefully and print answers to all questions.

Email: _____

1. Name _____ Social Security No. _____
Last First Middle

Phone No. _____

2. Address _____
Number Street City or Town State Zip Code

3. DATE YOU PLAN TO RETIRE _____ 4. Date of Birth _____
Month Day Year Month Day Year

5. Name of your Beneficiary _____ Relationship _____

Address of Beneficiary _____

5A. Spouse's Date of Birth _____ Marital Status _____
Month Day Year

6. List the names of all employers for whom you worked under a labor agreement with a Teamsters Local Union. Show dates of employments as best as you can.

Name of Employer	Address	Job Classification	Under Contract With Local Union No.	Employed	
				From Mo/Yr	To Mo/Yr

6A. Last Day You Worked **OR** Intend to Work _____

 Month Day Year

7. During any of the periods mentioned, were you an owner or part owner of any of the companies you worked for or were you working in a supervisory or managerial capacity? NO____ YES____
If YES, please explain.

8. You may be entitled to credit during a period when you were receiving disability benefits from the Welfare Fund or Workmen's Compensation benefits. Please list below such periods of disability or compensation occurring after September 1, 1952.

Name of Employer for whom you were working	Check One (x)		From		To	
	Disability	Workmen's Comp.	Mo.	Year	Mo.	Year

9. If you left covered employment to enter the Military Service, submit a copy of Separation Papers.

FROM: _____ **TO:** _____

 Month Year Month Year

DISABILITY PENSION

10. If you are applying for a Disability Pension complete the following and sign the authorization below.

- a. Date you first became disabled _____
- b. Nature of your disability _____
- c. Have you applied for Social Security Disability Pension? No____ Yes____
 If **YES**, have you received a decision on your application yet? No____ Yes____

If you have received a decision on your application, has it been approved or rejected? App____ Rej____
 If the application has been approved, submit together with the application the Certificate of Social Security Award.

_____ **MEMBER'S SIGNATURE** _____ **DATE** _____

AFFIDAVIT OF MARITAL STATUS

I, _____ being of full age and duly sworn accordingly to the law, herby depose and say that, as of the date set forth below.

- I am legally married and have provided a copy of my marriage certificate.

- I am NOT married.

- I am divorced and have provided a copy of my Final Divorce Decree and Property Settlement and/or Qualified Domestic Relations Order (QDRO).

- I am widowed and have provided a copy of my spouse's death certificate.

Date: _____

Signature: _____

Sworn and subscribed before me on this

_____ day of _____, 201__

Notary Public

Local 560 Benefit Funds
303 Molnar Drive
Elmwood Park, NJ 07407
1-866-560-FUND

Verification of Union Affiliation

PART A – Member’s Information (please complete and return to the Fund office)

To be completed by member:	Social Security # _____
Last Name _____	First Name _____
Date of Birth _____	Present Employer _____
Currently covered under a Contract with Local # _____	Previously covered under a contract with Local # _____ From _____ To _____
Initiation date _____	
_____	_____
Date	Signature

PART B – Union Information (please complete and return to the Fund Office)

To be completed by Local Union Office:

Local Union # _____ hereby certifies that _____
(member 's name)

Was a member from _____ to _____

Date	Authorized Signature
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Mailing Address
303 Molnar Drive
1st Floor
Elmwood Park, NJ 07407

Telephone 201-867-3553
Toll Free 866-560-FUND
Facsimile 201-305-8052

Dear Member:

From: Trucking Employees of North Jersey ~Pension Fund
303 Molnar Drive
Elmwood Park, New Jersey 07407

In order to better serve you and your family **please complete the reverse side of this page** with the information of a non-spouse and at a different address than you. This person will be contacted if mail is returned to the Fund or if we are having difficulty contacting you.

Remember, ALWAYS inform us in writing of any change of address, phone number or vital information in order to keep our records current.

We look forward to hearing from you.

Yours truly,

TENJ Pension Fund

Member: _____ SSN: _____

Contact Information other than a spouse and at a different address to you for Affidavit Purposes.

Name _____
Last First MI

Address _____
Number & Street

_____ City State Zip Code

Relationship to Member: _____

Birth Date: ____/____/____

Telephone Number: _____

Name _____
Last First MI

Address _____
Number & Street

_____ City State Zip Code

Relationship to Member: _____

Birth Date: ____/____/____

Telephone Number: _____

Authorization to Obtain Earnings Data from the Social Security Administration

Mail completed form to:	Social Security Administration PO Box 33011 Baltimore, MD 21290-3011	Requesting organization:	SSA Job No 8623 Index 01 Trucking Employees of North Jersey Pension Fund 303 Molnar Drive Elmwood Park, NJ 07407
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Number Holder's Information

First Name:	<input style="width: 100%; height: 20px;" type="text"/>	Middle Initial:	<input style="width: 100%; height: 20px;" type="text"/>
Last Name:	<input style="width: 100%; height: 20px;" type="text"/>		
SSN:	<input style="width: 100%; height: 20px;" type="text"/>		
Date of Birth:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	Month	Day	Year
Date of Death:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	Month	Day	Year
Other First, Middle Initial, and Last Name Used to Report Earnings:	<input style="width: 100%; height: 20px;" type="text"/>		
Year(s) Requested:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	through	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	Y Y Y Y		Y Y Y Y
	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	through	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
	Y Y Y Y		Y Y Y Y



I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

Signature of Number Holder (or authorized representative)		Date
		<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
		M M D D Y Y Y Y
Printed Name (if other than number holder)		Relationship (if other than number holder)
		<input type="checkbox"/> Spouse <input type="checkbox"/> Legal Representative <input type="checkbox"/> Other (specify)
Address	State	
City	ZIP Code	Phone Number

Requesting Organization's Information

SSA must receive this form within 120 days from the date signed by the Number Holder (or Authorized Representative)

Signature of Organization Official	Date
Phone Number	Fax Number

FOR SSA USE ONLY 1 2 3 4



IMPORTANT INFORMATION

**Privacy Act Statement
Collection and Use of Personal Information**

Section 205(c)(2)(A) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from furnishing detailed earnings information.

We will use the information to produce detailed earnings information about the wage earner. We may also share your information for the following purposes, called routine uses:

- To employers or former employers, including State Social Security administrators, for correcting and reconstructing State employee earnings records and for Social Security purposes; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0059, entitled Earnings Recording and Self-Employment published in the Federal Register (FR) on January 11, 2006, at 71 FR 1819. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***

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