trust fund office
local union 831
employer health fund
employer pension plan
P.O. Box 3118, Covina, California 91722-9118
Toll Free (877) 572-7005 • Phone (626) 279-3080 • Fax (626) 279-3055

IMPORTANT: PLEASE READ BEFORE COMPLETING APPLICATION

Dear Member:
Enclosed please find the Application for Retirement Benefits. Please read it carefully and provide all the information requested in order to expedite your request. Please submit with your application, proof of your age (a list of acceptable documents is attached), proof of age for your spouse and a copy of your marriage certificate or death certificate, if applicable. If you have been divorced, provide a copy of the court order which divides the pension benefits.

All Pension Benefits begin on the **first** day of the month. You may not work in Covered Employment at all for at least the full calendar month in which your pension starts. There are other restrictions on the kinds of work you may and may not perform during that first month and other rules about work you may and may not perform after your pension starts. These rules are summarized on the attached "Summary of the Plan's Retirement Rules" and the "Summary of Plan's Reemployment Rules."

Normal Retirement age is the later of age 60 or your fifth year of plan participation. Early retirement may begin as early as your age 50 provided you have completed the required number of Years of Benefit Service. An Early Retirement benefit is reduced ½ of 1% for each month your benefit commencement date precedes your Normal Retirement Date. However, if you have earned at least 30 years of Benefit Service when you retire, your benefit amount will not be reduced because of the early retirement. (See other side for more information on Early Retirement)

Your application can be submitted to our office as early as 180 days prior to the date you requested that Pension Benefits begin. Normal processing time for a Pension application is about 90 days.

We must give you and your spouse at least 30 days to choose the form of your pension benefit. But if you want a pension starting date that is less than thirty days after you get our explanation of those options, you and your spouse must complete and notarize the WAIVER OF 30-DAY ELECTION PERIOD FOR DISTRIBUTION OF BENEFIT FORM.

HEALTH & WELFARE PLAN

In order to continue your health benefits using the Retiree Health Plan, you must (1) complete the enclosed Retiree Benefit Selection Form; and (2) complete the forms that will be sent to you by the Health Plan. The Health Plan forms will tell you how much your premium will be, and will require that you sign an assignment that will take that amount out of your pension and pay it directly to the Health Plan to cover your premium.

Failure to complete and return these documents and to enroll in the Retiree Health Plan within 90 days of your last covered month of health benefits following your Retirement Date may result in your benefits being forever lost.

After we get your Benefit Selection Form, the Administrative Office will notify you of your eligibility for and the amount of subsidy that you are entitled to receive towards the cost of the Retiree Health Benefit.

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EARLY RETIREMENT EFFECTIVE DATE

You are eligible for an Early Pension if you retire on or after the date you meet the following age and Service requirements.

Birthday Attained Prior To Date of Retirement	Completed Years of Benefit Service
50	20 or more
51	19 or more
52	18 or more
53	17 or more
54	16 or more
55	15 or more
56	14 or more
57	13 or more
58	12 or more
59	11 or more

Please complete and return the following forms and documentation, keeping copies for your records:

- Application
- Proof of Age (Self & Spouse if applicable)
- Marriage Certificate (if applicable)
- Death Certificate (if applicable)
- Divorce Decree (if applicable) and any Qualified Domestic Relations Order dividing your pension.
- Social Security Disability Award Letter (if applicable)
- Certification of Termination of Employment
- Waiver of 30-day Election Period for Distribution of Benefits – Only if you are requesting a Pension Benefit Effective Date that is less than 30 days after the date you received the Explanation of Benefit Options (if applicable)
- Retirement Medical Selection Form (if applicable)

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APPLICATION FOR RETIREMENT BENEFIT

Complete the application in full and return it to the Administrative Office in the enclosed return envelope.

Name:_____ Social Security #: _____
First M.I. Last

Address:_____ Number and
Street City State Zip Code

Telephone #:_____ Date of Birth: _____

Date joined Local #831_____Last date worked/will work: _____

Have you ever worked for a contributing employer of Sign, Display and Allied Crafts Union, Local No. 510? ___Yes ___No

Specify the date you wish your pension benefit to begin: _____
*(All Pension Benefits begin on the **first** day of the month)*
(Please carefully read the attached rules about working during retirement before selecting your benefit start date. Following the rules will prevent having your pension revoked or suspended).

Pension Type (Select One)

☐ Normal (age 60 or older) ☐ Early (reduced) ☐ Early (30-N-Out) ☐ Disability**

If You Are Applying for An Early Retirement Benefit:

1. Are you disabled, even though you have not yet received a Social Security Disability Award?
   ☐ Yes ☐ No
2. If so, do you intend to convert your Early Retirement to a Disability Retirement upon receipt of a Social Security Disability Benefit award? ☐ Yes ☐ No
   (Note: If "yes", you must notify the Trust at least every 6 months of the status of your social security application. If you fail to do this you may be denied the right to convert to a Disability Benefit.)

Marital Status: (Check ALL that apply)

☐ Single (Never Married) ☐ Married ☐ Divorced* ☐ Widowed *

Spouse Name:_____ Social Security #: _____
First M.I. Last

Date of birth:_____Date of Marriage: _____

*If you are divorced or widowed, it is necessary that you submit proof of such. If you are divorced or widowed more than once, please send proof of each. Appropriate proof would be a copy of your final divorce decree including all pages of property settlement documents and your Qualified Domestic Relations Order or a copy of your spouse's death certificate.

**If you are requesting disability retirement, please provide us with a copy of your entire Social Security Disability Award Letter that shows the date you were found to be disable and the date of entitlement.

_____ _____
SIGNATURE OF APPLICANT DATE

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SUMMARY OF PLAN'S RETIREMENT RULES and REEMPLOYMENT RULE

The rules for retirement and reemployment are different for the first month that includes your retirement date than for the months after that first month, and the applicable rule also depends on the type of retirement and your age.

1. **Required Beginning Date**. Starting on the April 1 after the calendar year in which you become 70½ years old (called a "Required Beginning Date"), you may work in any capacity, including Covered Employment, for as many hours as you want.

2. **Normal or Late Retirement**. This is a retirement on or after your 60th birthday (or, if later, the fifth anniversary of your participation in the Plan).

   a. FIRST MONTH. During the calendar month which includes your pension start date you may not work in Covered Employment and you may not work in non-Covered Employment that is in the same industry, the same trade or craft, and in the same geographical area as covered by our Plan.

      EXCEPTION. You may work as many hours as you like in non-Covered employment for a Covered Employer.

   b. AFTER THAT FIRST MONTH, you may work no more than 40 hours in a month in employment, whether Covered Employment or otherwise, that is in the same industry, the same trade or craft, and in the same geographical area as covered by our Plan. With one Exception –

      EXCEPTION. You may work as many hours as you like in non-Covered employment for a Covered Employer.

   a. On April 1 of the calendar year after you reach age 70 ½, there are no plan restrictions on your ability to work.

3. **Early Retirement.** This is any retirement before your 60th birthday.

   a. FIRST MONTH. During the calendar month which includes your pension start date, you may not work in employment, whether Covered Employment or otherwise, that is in the same industry, the same trade or craft, and in the same geographical area as covered by our Plan.

      A further limitation is that you may not perform any work <u>at all</u> of any kind for any Employer that contributes to this Plan. In addition, at the time you retire you may not have any type of agreement or understanding with any Covered Employer that you will work for that employer after the end of that first pension month.

   b. AFTER THAT FIRST MONTH, you may work no more than 40 hours in a month in employment, whether Covered Employment or otherwise, that is in the same industry, the same trade or craft, and in the same geographical area as covered by our Plan.

      EXCEPTION. You may work as many hours as you like in any month in which you perform no Covered Employment if that work is in non-Covered employment for a Covered Employer.

   c. When you reach age 60, the rules for Normal Retirement will apply to you. On April 1 of the calendar year after you reach age 70 ½, there are no plan restrictions on your ability to work.

4. **Disability Retirement.** If you are disabled then you should not be working at all. Still, you might be eligible for a trial work period without jeopardizing your disability pension. Check with the pension office before starting on any such trial employment.

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ACCEPTABLE DOCUMENTATION MUST BE PROVIDED TO ESTABLISH DATE OF BIRTH FOR YOU AND YOUR SPOUSE, AND PROOF OF MARRIAGE.

DOCUMENTS MUST BE ORIGINALS OR CERTIFIED COPIES (MUST HAVE BLUE OR PURPLE OFFICIAL SEAL).

COPIES OF ORIGINALS OR OF CERTIFIED COPIES WILL NOT BE ACCEPTED.

Submit one of the documents listed in Group One or Two of the documents listed in Group Two. Original documents will be returned after being photocopied by the Fund's Representative.

GROUP ONE (Only one required from this group)

Birth Certificate

Baptismal Certificate

Record from family Bible or other family register of birth.

GROUP TWO (Any two required from this group)

Life Insurance policy at least five years old

School record

Confirmation record

Certificate of Military Service

California driver's license

Marriage record, if age at time of marriage or date of birth is shown

Naturalization record

Affidavit of older relative

Passport

GROUP THREE (Acceptable proof of marriage)

Marriage Certificate

Church Record certified by custodian of such record

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SOUTHERN CALIFORNIA UNION LOCAL 831 PENSION TRUST FUND
CERTIFICATION OF TERMINATION OF EMPLOYMENT
To be Completed by Participant

Participant Name: _____ SS#: _____
(Please Print)

I have read and understand the enclosed Plan's early retirement rules as summarized. I acknowledge that for the purposes of this *Certification,* the employer (s) listed below and all business entities affiliated with that employer, are to be considered the same employer.

1. My most recent Covered Employer is/was:
(*This is the name of the employer you last worked for in Covered Employment even if you are no longer working for that employer or are working in a non-covered position for that employer.)* ***If you worked for more than one employer, please list the others on a separate sheet of paper.***

   Employer Name:_____Industry/Trade/Craft: _____

   Address: _____

   _____

   Human Resources Contact Person:_____Phone# ( ) _____

2. My actual **Last Day of Work** for the above employer will be/was: _____

3. My **Last Paid Day** for the above employer will be/was: _____

4. Are you currently working in Non-covered Employment for this employer? ☐ Yes ☐ No

5. Do you intend to perform any service for any contributing employer (s) in any capacity (whether or not as Covered Employment) after your Pension Effective Date? ☐ Yes ☐ No, If *yes*, please explain on a separate sheet of paper.

Participant's Signature: _____ Date: _____

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SOUTHERN CALIFORNIA LOCAL 831 - EMPLOYER PENSION PLAN
EXPLANATION OF YOUR BENEFIT OPTIONS

INTRODUCTION

This Explanation of Benefit Options, which is part of your application packet for retirement benefits, explains the forms of payment that are available under the Pension Plan, and also explains the choice—available only to applicants who meet certain requirements—between retroactive payment and prospective payment. After reading this notice, if you wish to receive estimates of your accrued benefit adjusted for the available forms of payment, you may request this from the Administrative Office.

All benefits described in this Explanation are calculated as of the retiree's Annuity Starting Date. Your Annuity Starting Date is the effective date of your retirement benefit and will generally be the first day of the month after you submit your completed application for benefits, as long as you have ceased employment and met all of the eligibility requirements to receive a benefit as of that date. However, please see the section on page 3 of this notice describing "Prospective Payment and Retroactive Payment" and see the separate form titled "Waiver of 30-Day Notice Period."

"Normal Form of Pension"

The Plan defines the "Normal Form of Pension" as a **single life annuity with a 10-year certain period**. This means that the monthly benefit is payable for the lifetime of the retiree, and, upon the retiree's death, if benefits have been paid to the retiree for fewer than 120 months, then the payments continue to the designated beneficiary (in the same monthly amount as the retiree was receiving) until payment has been made for 120 months. At that time payments would cease.

Automatic Forms of Payment under the Pension Plan

- Benefits are paid in the automatic form that corresponds to your marital status on your Annuity Starting Date unless you (and your spouse, if any) properly reject the automatic form and elect an optional form of payment instead.

- If you are **unmarried** on your Annuity Starting Date, then the **automatic** form of payment is a **Single Life Annuity**. This means that monthly payments will be made for your lifetime, and will cease the month following your death. Unlike the "Normal Form of Pension" (described above), there is no "certain period" (guaranteed number of payments) with the Single Life Annuity. However, the monthly amount of the Single Life Annuity is adjusted to be the actuarial equivalent of the Normal Form. For example, if you are retiring at age 55 and your monthly benefit payable in the Normal Form would be $1,000, then your monthly benefit payable as a Single Life Annuity would be $1,037.

- If you are **married** on your Annuity Starting Date, then the **automatic** form of payment is a **50% Joint and Survivor Annuity** (this form of payment is also called the Plan's Qualified Joint and Survivor Annuity, or **QJSA**). Under the QJSA, monthly payments will be made for your lifetime, and, beginning with the month following your death, your surviving spouse will receive a lifetime monthly benefit equal to 50% of the monthly benefit you were receiving at the time of your death. Payments from the Plan would cease upon your surviving spouse's death. The monthly amount of the 50% Joint and Survivor Annuity or QJSA is adjusted to be the actuarial equivalent of the Normal Form (see page 1). For example, if you are retiring at age 55, and your monthly benefit payable in the Normal Form would be $1,000, and your spouse is also 55, then your monthly benefit payable as a 50% Joint and Survivor Annuity would be $964.90. Following your death, your surviving spouse would receive a lifetime monthly benefit of $482.45.

Optional Forms of Payment under the Pension Plan

If you are **unmarried** on your Annuity Starting Date, and you properly reject the automatic form of payment, then your benefits may be paid in the "Normal Form" (that is, a single life annuity with 10-year certain) instead of as a Single Life Annuity (with no guarantee period).

If you are **married** on your Annuity Starting Date, and you and your spouse properly reject the automatic form of payment, then your benefits may be paid in one of the following optional forms of payment:

1. the "Normal Form" (a single life annuity with 10-year certain, as described on page 1); or
2. a 75% Joint and Survivor Annuity as described below; or
3. a 100% Joint and Survivor Annuity as described below.

The 75% Joint and Survivor Annuity and the 100% Joint and Survivor Annuity are not available to unmarried applicants, and are not available to Disability Pension applicants.

- Under the **75% Joint and Survivor Annuity,** monthly payments will be made for your lifetime, and, beginning with the month following your death, your surviving spouse will receive a lifetime monthly benefit equal to 75% of the monthly benefit you were receiving at the time of your death. The monthly amount of the 75% Joint and Survivor Annuity is adjusted to be the actuarial equivalent of the Normal Form (see page 1). For example, if you are retiring at age 55, and your monthly benefit payable in the Normal Form would be $1,000, and your spouse is also 55, then your monthly benefit payable as a 75% Joint and Survivor Annuity would be $932.40. Following your death, your surviving spouse would receive a lifetime monthly benefit of $699.30.

- Under the **100% Joint and Survivor Annuity,** monthly payments will be made for your lifetime, and, beginning with the month following your death, your surviving spouse will receive a lifetime monthly benefit equal to 100% of the monthly benefit you were receiving at the time of your death. The monthly amount of the 100% Joint and Survivor Annuity is adjusted to be the actuarial equivalent of the Normal Form (see page 1). For example, if you are retiring at age 55, and your monthly benefit payable in the Normal Form would be $1,000, and your spouse is also 55, then your monthly benefit payable as a 100% Joint and Survivor Annuity would be $902.10. Following your death, your surviving spouse would receive a lifetime monthly benefit of $902.10.

Prospective Payment and Retroactive Payment

In addition to the election you (and your spouse, if any) will make as to the form of payment in which your Pension will be paid, if you are older than Normal Retirement Age (generally age 60) on your Annuity Starting Date (**ASD**), you may also have a choice between the following:

- Payment as of your Annuity Starting Date, with a monthly benefit calculated as a "Late Retirement." Under this calculation, your monthly benefit is the **greater** of (1) your total accrued monthly benefit as of the Late Annuity Starting Date, or (2) your accrued benefit at Normal Retirement Date actuarially increased to take into account the delay between your Normal Retirement Date and your Late ASD.

- Payment as of a Retroactive Annuity Starting Date (RASD). The RASD can reach back to the **later** of your Normal Retirement Date or the first day of the month following the month in which you terminated covered employment. Under a RASD, you receive back payments retroactive to the RASD date, and interest on the back payments at 4% per annum.

If you are eligible to choose between a Late Retirement calculation and a RASD, you may receive estimates of your accrued benefit adjusted for the prospective payment and retroactive payment by requesting this from the Administrative Office.

Important Tax Information

Please read the notice titled Special Tax Notice Regarding Plan Payments that you received with your application forms. This notice explains very important tax consequences of a Lump Sum payment (including the tax treatment of rollovers and possible liability for an additional 10% tax if you receive a distribution prior to age 59-1/2 that you do not roll over). We recommend that you read this tax notice before you complete the Application for Benefits and that you consult with your tax advisor if you have any questions.

ADDITIONAL INFORMATION

If you have any questions, please contact the Administrative Office at (877) 572-7005 or (626) 279-3080.

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LOCAL 831-EMPLOYER PENSION PLAN
WAIVER OF 30-DAY ELECTION PERIOD FOR DISTRIBUTION OF BENEFITS

Under IRS regulations, you have at least thirty days after receiving the explanation of the Plan's benefit payment options to decide how you want your retirement benefit paid. Your Annuity Starting Date (ASD) must not be less than thirty days after you are given the written explanation. For example, if you are given the explanation on the twenty-fifth day of the month, then your ASD will be on the first day of the **second** month following the month in which you were given the explanation, **unless** you and your spouse, if any, sign this form and file it with the Administrator. If the Administrator receives **this form**, properly completed, signed, and witnessed, and you are otherwise eligible under the Plan, then your ASD may be established as of the first day of the month immediately following the month during which you received the written explanation of available forms of payment. However, under no circumstances may the actual distribution of payments begin earlier than the eighth day following the day on which you (and your spouse, if any) were provided written explanation of the optional forms of benefit payment.

TO BE COMPLETED BY APPLICANT

I have applied for retirement benefits from the Plan with an Annuity Starting Date that is fewer than thirty days after the date on which I received the explanation of the Plan's qualified joint and survivor annuity and other available forms of payment. I recognize that, under federal law and regulations, the Plan would ordinarily not establish my ASD as of a date within the thirty days following the date on which this written explanation was provided to me (and my spouse, if any). Because I want my ASD to be established as of a date that is less than thirty days following the date on which this written explanation was provided to me, I, acting on behalf of myself, my heirs, successors and assigns, hereby authorize the Plan to dispense with that thirty-day waiting period, and I further agree not to challenge the validity of the form of payment elected by my spouse and me.

SSN:_____ PRINT NAME: _____

DATE:_____ APPLICANT'S SIGNATURE: _____

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

ACKNOWLEDGEMENT BEFORE NOTARY OR PLAN REPRESENTATIVE

Subscribed and sworn to before me this_____day of_____, 20____.

_____
Signature of Notary / Plan Representative

If Notary, both seal and signature are required on this form:

SEAL

My Appt. Expires: _____

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TO BE COMPLETED BY APPLICANT'S SPOUSE, IF ANY

My spouse has applied for retirement benefits from the Plan with an Annuity Starting Date that is fewer than thirty days after the date on which my spouse and I received the explanation of the optional forms of benefit payment. I recognize that, under federal law and regulations, the Plan would ordinarily not establish my ASD as of a date within the thirty days following the date on which my spouse and I received a written explanation of the Plan's benefit payment options. Because we do not want to wait for thirty days to have the ASD established, I, acting on behalf of myself, my heirs, successors and assigns, hereby authorize the Plan to dispense with that thirty-day waiting period, and I further agree not to challenge the validity of the form of payment elected by my spouse and me.

DATE:_____ SPOUSE'S SIGNATURE: _____

ACKNOWLEDGEMENT BEFORE NOTARY OR PLAN REPRESENTATIVE

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

Subscribed and sworn to before me this_____day of_____, 20____.

_____
Signature of Notary / Plan Representative

If Notary, both seal and signature are required on this form:

SEAL

My Appt. Expires: _____

Southern California Local 831 Employer Health Fund

RETIREE HEALTH COVERAGE ELECTION/PREMIUM DEDUCTION AUTHORIZATION

If you are a retiree interested in retiree health coverage or a retiree already receiving retiree health coverage under the Local 831 Employer Health Fund (the "Health Plan"), please complete the following and return to the Health Plan Office as soon as possible. Please note that if you elect this coverage you are required to make monthly premium payments to the Health Plan through an "after tax" and "voluntary" premium deduction from your monthly pension check from the Local 831 Employer Pension Fund.

Election for Retirees, Spouses, and/or Dependent Children NOT Eligible for Medicare

☐	I elect retiree health coverage and agree to have the premiums withdrawn from my monthly pension check.

Retiree's Last Name:	First Name:	MI:	Soc. Sec. No.:	
Street Address:	City:		State:	Zip:
Home Phone:	Daytime Phone:		DOB:	

IMPORTANT NOTICE: RETIREE HEALTH COVERAGE IS NOT AVAILABLE TO YOU OR TO YOUR DEPENDENTS IF YOU ARE, OR WHEN YOU LATER BECOME, ELIGIBLE FOR MEDICARE. HOWEVER, IF YOU BECOME ELIGIBLE FOR MEDICARE BECAUSE OF A DISABILITY BEFORE YOU TURN AGE 65, YOUR DEPENDENTS WILL BE ABLE TO CONTINUE RETIREE HEALTH COVERAGE FOR THE SAME DURATION AS IF THEY HAD INSTEAD ELECTED COBRA CONTINUATION COVERAGE.

EVEN IF YOU ARE ENTITLED TO RETIREE HEALTH COVERAGE, IT IS NOT AVAILABLE TO A DEPENDENT IF THE DEPENDENT IS, OR WHEN THE DEPENDENT LATER BECOMES, ELIGIBLE FOR MEDICARE.

Rates are as of January 1, 2024.

I ELECT retiree health coverage at the following level and Plan option (circle one of each):			
☐ Level 1: $ 1,806.00 *(Full Coverage)*	☐ Level 2: $ 1,548.00 *(Full Coverage)*	☐ Level 3: $ 1,290.00 *(Medical, Dental & Rx)*	☐ Level 4: $ 1032.00 *(Medical Only)*
☐ Indemnity Plan		☐ Kaiser Plan	
You will automatically be enrolled in the level of coverage and Plan option that you had on your last day as an Active Participant. However, you may choose to elect a lower level of coverage now or at any time in the future. You are only allowed to increase your level of coverage or switch between the Kaiser and Indemnity Health Plan options one time during the twelve (12) month period after you have elected retiree health coverage. A new assignment will be required every year.			
☐ I DO NOT wish to elect retiree health coverage.		☐ I wish to CANCEL my retiree health coverage and all premium deductions.	

WARNING: I understand that by **not electing** retiree health coverage or by **canceling** my retiree health coverage at this time, I can NEVER elect retiree health coverage under the Health Plan again.

* *If you meet the eligibility requirements and enroll in retiree health coverage provided through the Health Plan, you may also enroll your children and your lawful spouse as dependents, provided that (1) your children and spouse become enrolled in retiree health coverage at the same time that you enroll; (2) your children and spouse were covered under the Active Health Plan when you first became eligible for retiree health coverage; and (3) your spouse agrees, in writing, to receive retiree health coverage from the Health Plan instead of electing COBRA continuation coverage, which would result in a waiver of their right to participate in COBRA continuation coverage. You may not later add your children or your lawful spouse even if you were not married at the time you enrolled in the Health Plan and subsequently married, or if you divorced and subsequently re-married.*

Note: If you are, or become, covered under your spouse's plan, or become covered under our Active Health Plan, you may suspend coverage and premium payments under this Retiree plan while you are so covered. But you must provide the written notices explained on page [74] of the SPD.

Provide the name, address and details of any other group health plan that you, your spouse, or your dependent children are covered under through your or their employment:

_____

_____

_____

Provide the name(s) of your spouse/dependents, if any, that you would also like covered:

_____

_____

I hereby authorize the Pension Fund Office on behalf of the Pension Plan to deduct from my monthly pension benefit payment, on an after-tax basis, the amount (but not to exceed my gross monthly pension benefit after withholdings for income taxes) that has been determined by the Trustees of the Health Plan to be paid by me as a retiree participant in the Health Plan, to maintain my retiree health coverage in full force and effect.

I understand that I **am under no obligation** to enter into this arrangement for the payment of the retiree share of retiree health coverage, and that this assignment of benefits to the Health Plan for this purpose may **be revoked** at any time.

I also understand that this is on an "after- tax" basis and that this election will not affect the gross income that will be reported to the Internal Revenue Service on my behalf.

For those with post-retirement work hours, employer contributions made towards retiree health coverage will be reviewed quarterly.

Signature of Participant:	Date:
Signature of Spouse:	Date: