Central Laborers' Pension Fund
PO Box 1267 ◆ Jacksonville, IL 62651-1267
Phone 217-243-8521 or 800-252-6571

App#

Application for Disability Benefit or Occupational Disability Benefit

To determine whether you may meet the Fund's eligibility requirements for a Disability Benefit or an Occupational Disability Benefit, please consult your copy of the Summary Plan Description of the Central Laborers' Pension Fund which details the eligibility requirements for each of these benefits. If you do not have this document, please visit the Fund's web site, www.central-laborers.com, or contact the Fund Office.

1. Please read each question carefully.
2. Print all information.
3. Please answer all applicable questions and provide the necessary documents to avoid delay in processing your application.
4. Attach additional pages if you need more space to answer any questions.
5. Be sure to sign and date this application.
6. Please submit the Proof of Disability Form completed by you and your physician.
7. Please submit the signed Medical Release, Applicant Release, and Social Security Administration Consent for Release of Information.
8. Mail the completed application and documentation to the address shown above.

Part I. Descriptions of the Disability Benefit and the Occupational Disability Benefit

Disability Benefit

A Disability Benefit is not a pension; it is a monthly benefit available in the event you are unable to work due to a total and permanent disability. If you are eligible for a Disability Benefit, you will be asked to elect how you want your benefit paid (a Life Only Pension, a 50%, 75%, or 100% Joint and Survivor Spousal Pension). If you are married and elect a Life Only form of payment, your spouse must consent to waive the 50% Joint and Survivor Spousal Pension in accordance with the Fund's Rules and Regulations. If eligible, the monthly amount of a Disability Benefit will equal the monthly amount of your Regular Pension benefit earned as of the date you became disabled, assuming payment as a Life Only Pension (if your benefit is paid in another form, your monthly benefit will be adjusted in accordance with the Fund's Rules and Regulations). Disability Benefits are not part of your accrued pension.

Occupational Disability Benefit

The Occupational Disability Benefit is not a pension; it is a temporary monthly benefit payable until you recover, retire, or die. When you are eligible to retire on a Regular, Early Retirement, or Service Pension, you will be asked to elect how you want your pension to be paid. In the event of your death while receiving an Occupational Disability Benefit, all benefit payments end. However, if you are married, your surviving spouse may be eligible to receive a Pre-Retirement Surviving Spouse Pension as if you had died while actively employed. If eligible, the monthly amount of an Occupational Disability Benefit will be 50% of your Regular Pension amount earned as of the date you became occupationally disabled and calculated as if you retired and received payment as a Life Only option. Occupational Disability Benefits are not part of your accrued pension and will not affect the monthly amount of your or your survivor's benefit upon your retirement or death.

Part II. Request for Disability Benefit or Occupational Disability Benefit

		*Yes	No
I am applying for:	**Disability Benefit**	☐	☐
	Occupational Disability Benefit	☐	☐

***Important:** A Participant who may not be eligible for a Disability Benefit may be eligible for an Occupational Disability Benefit. For this reason, you may mark "Yes" for Disability Benefit and Occupational Disability Benefit. If you do this, the Fund will first consider whether you meet the requirements of a Disability Benefit. If you are not eligible for a Disability Benefit, the Fund will then consider whether you are eligible for an Occupational Disability Benefit. In any event, after considering your application, the Fund will notify you of whether you are eligible for the Disability Benefit or Occupational Disability Benefit. *For purposes of your appeal rights, you may appeal the Fund's initial determination that you are not eligible for a Disability Benefit, even if the Fund finds that you are eligible for an Occupational Disability Benefit.* (For more information on the Fund's claims and appeals procedures, please consult your copy of the Summary Plan Description.)

Part III. Your Personal Information

Name_____ Date of birth**_____
(last) (first) (middle) Month/Day/Year

Address _____
(number and street) (city) (state) (zip code)

Social Security Number _____ Telephone Number _____

Are you married: ☐ Yes ☐ No (If "yes", complete the following)

Spouse's name _____ Spouse's SSN _____

Spouse's date of birth ** _____ Date of marriage ** _____
Month/Day/Year Month/Day/Year

Are you considering or currently in the process of obtaining a divorce: ☐ Yes ☐ No
Were you previously married and divorced: ☐ Yes ☐ No
If "yes", please provide a complete, certified copy of the Divorce Decree and Property/Marital Settlement Agreement.

Have you ever served in the armed forces of the United States? ☐ Yes ☐ No

_____ _____ _____
Branch of Service Date Entered Date of Discharge or Separation**

**Submit proof – See enclosed instructions

Local Union #, City/State _____ LIUNA Membership # _____

Dates of Union membership From _____ To_____

What other Laborers' Local Unions have you belonged to: Check here if none ☐

_____ _____ From_____ To_____
Local Union # Location/City & State Dates of Union membership

Are you receiving or eligible to receive pension benefits from other pension plans due to your employment as a laborer? ☐ Yes ☐ No If "yes", provide name of Plan _____

Name of current or most recent employer _____

The last day I worked was or will be _____

Are you now or have you ever been unable to work because of total disability? ☐ Yes ☐ No
If "yes", cause of disability: _____ From_____ To_____

Have you applied for Social Security disability benefits? ☐ Yes ☐ No
Please provide the address of your Social Security office:_____
If you have applied for SSA disability benefits, have you received a SSA disability award? ☐ Yes ☐ No
If you have received a SSA disability award, what is the date of that award? _____
If you have been awarded Social Security disability benefits, include a copy of the Social Security award certificate with this application. Also, please complete and return the enclosed Social Security Administration "Consent for Release of Information".

Nature of disability: _____

When did you become disabled? _____

Name and address(es) of your physician(s): _____
_____

Have you worked at any occupation since you became disabled? ☐ Yes ☐ No
If "yes", describe your work and periods of employment: _____

_____

Part IV. Signature and Certification

I hereby apply for benefits from the Central Laborers' Pension Fund and certify that all statements in this application are true and accurate to the best of my knowledge and belief. If benefits are awarded to me, I agree to be bound by all of the Rules and Regulations of the Pension Fund. I understand that in the event of an overpayment of my benefits, the Trustees are entitled to recover any amounts overpaid to me. Also, if no information appears in the spouse's section above, I certify that I am not married.

_____ _____
Date **Signature of Applicant**

Part V. Commencement of Payment of Benefits

If you believe you are disabled and may be eligible to receive a Disability Benefit or an Occupational Disability Benefit, you should submit this Application to the Fund Office as soon as possible in order for the Fund to review your application and supporting documentation. If the Fund determines that you are eligible to receive a Disability Benefit or an Occupational Disability Benefit, monthly payments will commence on your "earliest disability commencement date" which is defined in the Fund's Rules and Regulations as the first day of the month following the date a completed application for benefits is filed with the Fund Office. If determined to be eligible, at the time your monthly Disability Benefit or Occupational Disability Benefit payments begin, you may also receive a supplemental payment equal to the amount of the monthly benefit for each month retroactive to the date you were deemed to be totally and permanently disabled or occupationally disabled in accordance with the Fund's Plan Rules and Regulations; the supplemental payment shall not exceed 36 months from the earliest disability commencement date. In no event can an Occupational Disability Benefit be paid for any period prior to October 1, 2004.

The Disability Benefit and the Occupational Disability Benefit are not part of a participant's accrued pension, are not protected benefits under Internal Revenue Code Section 411(d)(6), and may be reduced or eliminated at any time in the sole discretion of the Trustees.

In the event the Fund determines you are not eligible for a Disability Benefit or an Occupational Disability Benefit, you may appeal such adverse determination(s) in accordance with the Fund's Claims and Appeals Procedures for Disability claims as set forth in your Summary Plan Description.

CENTRAL LABORERS' PENSION FUND
PROOF OF AGE

In applying for benefits, the Fund office needs to receive proof of your age as well as your spouse's age (if married). The following list shows the type of documents that may be submitted. Some documents are preferred over others, and the list is arranged in order of preference.

Please furnish the best type of proof of age that is available. Additional proof may be required if the document you submit cannot be accepted. Photocopies of the documents **may** be submitted.

NOTE: Naturalization Papers, United States Passports and Immigration Papers **MAY NOT** be photocopied. If any of these documents are the only proof of age you have, please submit the original document and it will be returned to you.

1. Birth Certificate
2. A baptismal certificate or statement as to the date of birth shown by a church record, certified by the custodian of such record
3. Notification of registration of birth in public registry of vital statistics
4. Hospital birth record, certified by custodian of such record
5. A foreign church or government record
6. A signed statement by a physician or midwife who was in attendance at birth, as to the date of birth shown on their records
7. Naturalization Records
8. Immigration Papers
9. Military Record
10. Passport
11. School record, certified by the custodian of such record
12. Vaccination record, certified by the custodian of such record
13. An insurance policy which has been in force at least ten (10) years and which shows the age or date of birth
14. Marriage records showing date of birth or age (application for Marriage License or church record, certified by the custodian of such record, or Marriage Certificate)
15. Other evidence such as signed statements from persons who have knowledge of the date of birth, voting record, etc.
16. Certification of record of age by the United States Census Bureau
17. Illinois Real ID with Gold Star Designation (standard ID or driver's license cannot be accepted)

PROOF OF MARRIAGE: A photocopy of your Marriage License will be accepted; however, it is preferred that you submit the original. A copy will be made and the original will be returned to you.

PROOF OF DIVORCE: Your complete certified divorce records for all former spouses, including all Orders of the Court (adequate waiver of claim language or an award of benefits to an alternate payee per a Qualified Domestic Relations Order is required).

MILITARY SERVICE: If you have served in the Armed Forces of the United States, please submit a photocopy of your discharge documents.

CENTRAL LABORERS' PENSION FUND AUTHORIZATION

For the Use and Disclosure of Health Information

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. *This does not keep the information from being shared with more people once it leaves our office.* This authorization will only last until the date you specify, but not longer than one year. If you decide later that you do not want us to share your information any more, you can sign the REVOCATION SECTION at the end of this form and return it to us.

Date: _____

Person or Group Needing the Health Information: Central Laborers' Pension Fund

I give permission to _____ to share the health information checked below with the person or group listed above:

☐ All information

☐ Information from a certain time period (specify dates):

From _____ To _____

☐ All information relating to a certain event or injury – *example: left knee injury from December 2010* (specify event and dates):
Event _____
Date of Event _____

☐ Other (specify): _____

Printed Name:_____ Signature: _____

Signature of Authorized Representative _____ Date _____

Relationship of Authorized Representative _____

REVOCATION SECTION

I no longer want my information shared.

Signature _____ Date _____

Central Laborers' Pension Fund

P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/245-1293

http://www.central-laborers.com

TO WHOM IT MAY CONCERN

I hereby request and authorize you to disclose to the Central Laborers' Pension Fund any and all information and reports you may have concerning the medical condition for which you and/or other physicians have been treating me, including medical history, consultation, treatment, etc.

I further request and authorize you to express such opinions as may be requested by the Central Laborers' Pension Fund with regard to the existence/extent of my disability, if applicable.

Dated this _____ day of _____, _____.

_____
Participant's Name

_____
Participant's Signature

_____
Participant's Social Security Number

Central Laborers' Pension Fund

Proof of Disability Form
For Non-Work Disability Pension Credit

Instructions: The Pension Plan provides Non-Work Disability Pension Credit to Laborers who are unable to perform their usual occupational duties as a result of a disability. Please have your Doctor complete the Physician's Statement on the reverse side.

Employee's Statement

Name _____ Social Security Number _____
Last First Middle

Address _____
Street City State Zip Code

Birth Date _____ Local Union No. _____ Initiation Date _____

Type of Disability: (Check one and complete the requested information)

- ☐ **Occupational Disability**
  1. Disability due to: _____
  2. Period of disability from _____ to _____
     Month/Day/Year Month/Day/Year

     I received Worker's Compensation from _____ to _____ as a
     Month/Day/Year Month/Day/Year
     result of the on-the-job disability described above and documents substantiating my Worker's Compensation award for the period shown are attached.

- ☐ **Non-Occupational Disability**
  1. Non-Occupational Disability due to ☐ Accident ☐ Sickness
  2. Description of disability _____
  3. Period of disability from _____ to: _____
     Month/Day/Year Month/Day/Year
  4. Date of first doctor's treatment _____
     Month/Day/Year

Your doctor's statement as to the nature of your disability must be included on the form provided on the reverse side of this application, regardless of whether you are applying for occupational or non-occupational disability.

I hereby apply for Non-Work Disability Pension Credit based on the proof submitted herein. I have provided all of the required information about my occupational or non-occupational disability and I certify that the information is true and correct. I also request and authorize my physician to complete this form and submit the information to the Pension Fund.

_____ _____
Date Employee Signature

Statement of the Attending Physician

Name of Employee:_____ Phone Number_____

Present Address: _____
Street City State

History:

- Disability due to ☐ Illness ☐ Injury due to accident
- When did present illness begin, or injury occur? _____
Month/Day/Year
- Date employee was obliged to cease work? _____
Month/Day/Year
- Patient has been continuously disabled (unable to work) from _____ to _____
Month/Day/Year Month/Day/Year
- Is there a previous history of this illness? ☐ Yes ☐ No
- Did sickness or injury arise out of patient's employment? ☐ Yes ☐ No If "yes" please explain

Diagnosis:

_____

_____

Treatment:

- Date of first visit _____ (Month/Day/Year)
- Date of last visit _____ (Month/Day/Year)
- Frequency of visits _____
- When did you last examine the Employee? _____ (Month/Day/Year)
- When do you recommend reexamination? _____ (Month/Day/Year)

Progress:

☐ Recovered ☐ Unimproved
☐ Improved ☐ Retrogressed

Degree of Disability:

- Has the Employee been able to perform any work; if so, from what dates?

Regular Work as a Laborer _____ Other Work _____
Month/Day/Year Month/Day/Year

- If not, when do you think he/she will be able to work?

☐ Approximate date _____ (Month/Day/Year)
☐ Indefinite
☐ Never

(please print)
Doctor's Name_____ Telephone _____
Address _____

_____M.D. _____
Signature Date

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

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 control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME OF PERSON OR ORGANIZATION:	*ADDRESS OF PERSON OR ORGANIZATION:
Central Laborers' Pension Fund	PO Box 1267, Jacksonville, IL 62651-126

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

This information will assist the Central Laborers' Pension Fund in determining whether I am eligible for a disability benefit with the Fund.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)
   All medical and related records used in determining disability and the SSA "Disability Determination and Transmittal"

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Central Laborers' Pension Fund
Applicant Release Authorization

I. In connection with my application for disability benefits with the Central Laborers' Pension Fund, I understand that the Central Laborers' Pension Fund may request information from public and private sources about, but not limited to, my workers' compensation injuries, current and prior employment, driving record, education, and credentials.

II. I acknowledge that a telephonic facsimile (FAX) or photographic copy shall be as valid as the original. This release is valid for most federal, state, and county agencies.

III. I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, LIUNA and/or affiliated office, or insurance company contacted by the Central Laborers' Pension Fund or its agent, to furnish the information described in Section I.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purpose. I hereby release the Central Laborers' Pension Fund and agents and all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the requests for or release of any of the above-mentioned information or reports.

Please print your full name LAST FIRST MIDDLE

Please print other names you have used

Current Address

City State ZIP Code

Social Security Number Date of Birth

The following states require gender and race to obtain information: AL, AR, FL, GA, IA, IL, IN, MI, OR, SC, TX, WI

Gender: ☐Male ☐Female **Race:** ☐Asian ☐African-American ☐Hispanic ☐White ☐Other

Driver's License Number State Issuing License Name as it appears on license

I CONFIRM THAT THE INFORMATION I PROVIDED ON THIS FORM IS TRUE AND CORRECT.

Signature Date

CENTRAL LABORERS' PENSION AND ANNUITY FUNDS' AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

YOUR ENTITLEMENT TO CERTAIN BENEFITS AS A RESULT OF YOUR MEMBERSHIP IN YOUR LOCAL UNION OR AS A PARTICIPANT IN OTHER FRINGE BENEFIT FUNDS MAY DEPEND ON YOUR STATUS WITH THE CENTRAL LABORERS' PENSION FUND. THIS AUTHORIZATION PERMITS THE DISCLOSURE OF PERSONAL INFORMATION TO YOUR LOCAL UNION AND/OR DISTRICT COUNCIL AND FRINGE BENEFIT FUNDS.

SECTION A – PARTICIPANT INFORMATION

Print Name: _____

Social Security #_____

SECTION B – DEFINITION OF PERSONAL INFORMATION AND AUTHORIZATION OF DISCLOSURE

I understand that Personal Information is information that includes my name, address, date of birth, Social Security number, telephone numbers, email address, earnings/tax records, beneficiary designation, eligibility status, benefit history, bank account information, Federal Employer Identification Numbers (FEIN), and amounts and/or value of benefits, and I hereby authorize the Pension Fund to disclose such Confidential Information to my Local Union, affiliated District Council, and any Fringe Benefit Fund in which I participate (including as an example only, the North Central Illinois Laborers' Health and Welfare Fund, Southern Illinois Laborers' and Employers Health and Welfare Fund, and other applicable funds).

SECTION C – PARTICIPANT'S ACKNOWLEDGMENT AND SIGNATURE

I hereby acknowledge that I have had an opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my approval and authorization of the use and/or disclosure of my Personal Information, as described in this form. I further acknowledge that my signature on this Authorization is voluntary and that if I refuse to sign this form it will not affect my benefits under the Plan. I understand that I have a right to revoke this Authorization, but any such revocation must be in writing and submitted to the Fund Office.

_____
Signature

Date: _____

Central Laborers' Pension Fund

P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/245-1293

http://www.central-laborers.com

Section 1.41. Total and Permanent Disability and Occupational Disability

(a) Total and Permanent Disability:

For purposes of Section 3.3(a) ("Disability Benefit"), Total and Permanent Disability shall mean that, in the opinion of a licensed medical practitioner selected or approved by the Trustees, the Participant, as a result of bodily injury or disease not resulting from an intentional self-inflicted injury, is totally and permanently able neither to:

(1) Engage in any further employment or gainful pursuit as a laborer or other building trades crafts employment in the construction industry for remuneration or profit, regardless of the amount, nor

(2) Engage in further employment or gainful pursuit of non-laborer or other non-building trades crafts employment for which the employment is considered full-time or a primary source of income.

A Total and Permanent Disability must be considered total and permanent and be expected to continue during the remainder of the Participant's life. The Trustees shall have sole and exclusive authority to determine whether a Participant has suffered a Total and Permanent Disability.

The Trustees at their discretion may accept as evidence of Total and Permanent Disability a determination by the Social Security Administration that the Participant is entitled to a Social Security Disability Income or any other Social Security Administration benefit based on disability ("Social Security Disability Benefit") in connection with his Old Age and Survivor's Insurance Coverage.

(b) Occupational Disability:

For purposes of Section 3.3(b) ("Occupational Disability Benefit"), an Occupational Disability shall mean that, in the opinion of a licensed medical practitioner selected or approved by the Trustees the Participant, as a result of bodily injury or disease not resulting from an intentional self-inflicted injury, is totally and permanently unable to engage in any further employment or gainful pursuit as a laborer or other building trades crafts employment in the construction industry for remuneration or profit, regardless of the amount. An Occupational Disability must be considered total and permanent and be expected to continue during the remainder of the Participant's life. The Trustees shall have the sole and exclusive authority to determine whether a Participant has suffered an Occupational Disability.

Central Laborers' Pension Fund

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http://www.central-laborers.com

Section 3.3. Disability Benefit and Occupational Disability Benefit

(a) Disability Benefit.

A Participant may be eligible to receive a Disability Benefit if he:

(1) Has suffered a Total and Permanent Disability as defined in Section 1.41(a);

(2) Has earned at least five (5) Years of Vesting Service prior to suffering a Total and Permanent Disability, and

(3) Worked at least 250 Hours of Work in Covered Employment during the Plan Year in which he suffered a Total and Permanent Disability, or in either of the immediately preceding two (2) Plan Years.

The Disability Benefit is not part of the Participant's Accrued Pension, is not a protected benefit under Code Section 411(d)(6), and may be reduced or eliminated at any time in the sole discretion of the Trustees.

(b) Occupational Disability Benefit.

A Participant may be eligible to receive an Occupational Disability Benefit if he:

(1) Has suffered an Occupational Disability (as defined in Section 1.41(b)) on or after October 1, 2004, while working as a laborer or in other building trades crafts;

(2) Has earned at least five (5) Years of Vesting Service prior to suffering an Occupational Disability, and

(3) Worked at least 250 Hours of Work in Covered Employment during the Plan Year in which he suffered an Occupational Disability, or in either of the immediately preceding two (2) Plan Years.

The Occupational Disability Benefit is not part of the Participant's Accrued Pension, is not a protected benefit under Code Section 411(d)(6), and may be reduced or eliminated at any time in the sole discretion of the Trustees.

(c) This Section 3.3(c) shall apply to Participants whose eligibility for benefits is based on work for Non-Construction Employers who become signatory to a Collective Bargaining Agreement on or after May 1, 1998, and to Participants whose eligibility for benefits is based on work for Employers with non-bargained Employees who become signatory to a Participation Agreement on or after May 1, 1998. Such a Participant shall not be eligible for an Occupational Disability Benefit. However, he may be eligible to receive a Disability Benefit if he:

(1) Has suffered a Total and Permanent Disability as defined in Section 1.41(a);

(2) Has earned at least five (5) Years of Vesting Service prior to commencement of his disability, and

(3) Worked at least 1,000 Hours of Work in Covered Employment during the Plan Year in which he suffered a Total and Permanent Disability or in the immediately preceding Plan Year.

(d) Disability Benefit or Occupational Disability Benefit payments shall commence on the first day of the month following the date a completed application for benefits is filed with the Fund Office (the "earliest disability commencement date").

(1) If the Board of Trustees determines that a Participant is deemed to be totally and permanently disabled or occupationally disabled as defined in Section 1.41 of the Plan on a date that is before a Participant's earliest disability commencement date, then such Participant shall receive a supplemental payment that is equal to the amount of the Participant's monthly Disability Benefit or Occupational Disability benefit, as applicable, for each month retroactive to the date that the Board of Trustees determined that such participant was deemed to be totally and permanently disabled or occupationally disabled. The supplemental payment shall not exceed 36 months from the earliest disability commencement date. Supplemental payments hereunder are not payments pursuant to a Retroactive Annuity Starting Date.

(2) If a Participant who is entitled to a supplemental payment as set forth in Subsection (d)(1) dies before he receives the payment (but after he submits an application for benefits), then the payment described in Subsection (d)(1) above shall be payable to the Participant's Designated Beneficiary.

(3) In the event a Participant who is married to a Qualified Spouse –

(A) Dies after he submits to the Fund Office a completed application for a Disability Benefit but before a determination is made as to the Participant's eligibility for a Disability Benefit;

(B) Elected to receive his benefit as a 50% Joint and Survivor Spousal Pension or as a 75% or 100% Joint and Survivor Spousal Pension Option; and

(C) Would have been eligible for a Disability Benefit had he not died,

then the benefit payable to the Participant's Surviving Spouse shall be determined as if the Participant died on what would have been his earliest disability commencement date (or a previously determined date of disability as in the case of the award of a Social Security Administration Disability Benefit), for purposes of determining the form and amount of the Qualified Spouse's survivor benefit, rather than in accordance with Sections 6.5, 6.6 or 6.7 of the Plan.

(e) Termination of Disability Benefit or Occupational Disability Benefit:

(1) The last payment of a Disability Benefit shall be made on the first day of the month preceding the earlier of the following:

(i) The day the Participant, or his Qualified Spouse, die, depending on the optional form of payment elected by the Participant and his Qualified Spouse in accordance with Sections 6.1, 6.2 or 6.3; or

(ii) The first day of the month in which the Trustees determine that cessation of his Total and Permanent Disability occurred.

For purposes of Subparagraph 3.3(e)(1)(ii), cessation of a Participant's Total and Permanent Disability shall include, but not be limited to, the Social Security Administration's final determination that the Participant is not eligible for a Social Security Administration Disability Benefit or, in the case of a Participant who has previously been awarded a Social Security Administration Disability Benefit, a final determination by the Social Security Administration that the Participant is no longer eligible for a Social Security Administration Disability Benefit because he is no longer totally disabled. A final determination of the Social Security Administration shall be considered the earlier of the date the Participant exhausts his administrative appeal rights as established by the Social Security Administration or the date the Participant fails or refuses to appeal the Social Security Administration's determination that the Participant is not (or ceases to be) totally disabled and ineligible for a Social Security Administration Disability Benefit.

(2) The last payment of an Occupational Disability Benefit shall be made on the earliest of:

(A) The first day of the month preceding the Annuity Starting Date of his Regular Pension, Early Retirement Pension, Service Pension, or Disability Benefit;

(B) The first day of the month in which the Trustees determine that cessation of his Occupational Disability occurred; or

(C) The first day of the month in which he died.

In the event a Participant dies after commencing receipt of an Occupational Disability Benefit, the rights of the Participant's Beneficiary or Surviving Spouse shall be determined in accordance with Plan Sections 6.5, 6.6 and 6.7.

(3) Eligibility for a Disability Benefit or Occupational Disability Benefit shall be considered to have ceased, and the Disability Benefit or Occupational Disability Benefit shall be terminated, if the Participant:

(A) (i) In the case of a Disability Benefit, returns to employment as a laborer or other building trades crafts employment in the construction industry for remuneration or profit, regardless of the amount, or returns to full-time employment or employment that is considered a primary source of income, as a non-laborer or in a non-building trades crafts employment, or,

(ii) In the case of an Occupational Disability Benefit, returns to Covered Employment or any employment as a laborer or other building trades crafts employment in the construction industry for remuneration or profit, regardless of amount;

(B) In the opinion of the Trustees, based on medical findings, has sufficiently recovered to be able to resume employment as described in (A)(i) or (A)(ii) above (whichever is applicable); or

(C) Refuses to undergo such medical examination or furnish such reasonable information as may be requested by the Trustees.

(4) Any Participant who receives a Disability Benefit who subsequently ceases to be Totally and Permanently Disabled may:

(A) Apply for an Early Retirement Pension, Service Pension, or a Regular Pension provided he has fulfilled the age and service requirements for such Early Retirement, Service or Regular Pension. The Early Retirement, Service or Regular Pension shall become payable for the month immediately following the month in which the Disability Benefit shall terminate, or such later date as elected by the Participant, and the amount shall be equal to his Early Retirement, Service or Regular Pension; or

(B) Apply for an Occupational Disability Benefit, provided he has fulfilled the definition of "Occupational Disability" as defined in Section 1.41(b); or

(C) Return to Covered Employment.

(5) Any Participant who receives an Occupational Disability Benefit who subsequently ceases to be Occupationally Disabled may:

(A) Apply for an Early Retirement Pension, Service Pension, or a Regular Pension provided he has fulfilled the age and service requirements for such Early Retirement, Service or Regular Pension. The Early Retirement, Service or Regular Pension shall become payable for the month immediately following the month in which the Occupational Disability Benefit shall terminate, or such later date as elected by the Participant, and the amount shall be equal to his Early Retirement, Service or Regular Pension; or

(B) Apply for a Disability Benefit, provided he has fulfilled the definition of "Total and Permanent Disability" as defined in Section 1.41(a); or

(C) Return to Covered Employment.

(f) If a completed application for a Disability Benefit is filed with the Fund Office, and subsequently approved for payment by the Trustees but the Participant dies before his Disability Benefit payments would have begun, such Disability Benefit will be paid to the surviving Qualified Spouse or named Beneficiary in accordance with the application as if the Disability Benefit had commenced.

(g) Failure to Comply with Reporting and Disclosure Requirements:

(1) A Participant receiving a Disability Benefit or Occupational Disability Benefit shall report any and all earnings from any employment or gainful pursuit to the Fund Office in writing within fifteen (15) days after the end of each calendar year for which he had such earnings.

(2) A Participant receiving a Disability Benefit or Occupational Disability Benefit shall furnish an annual release whereby the Trustees may obtain Social Security Administration earnings information within fifteen (15) days after the Participant receives a request from the Fund Office for such release.

(3) In the event the Social Security Administration determines that a Participant receiving a Disability Benefit under this Plan ceases to be eligible for a Social Security Disability Benefit, the Participant shall notify the Fund Office within fifteen (15) days of being notified by the Social Security Administration of that determination.

If a Participant receiving a Disability Benefit or Occupational Disability Benefit fails to make timely reports as described in Subsection (1) hereof, fails to provide an annual release as described in Subsection (2) hereof or, in the case of a Participant who is receiving a Disability Benefit, fails to provide timely notice to the Fund Office as described in Subsection (3) hereof, or fails to comply with any other reporting and disclosure requirement described in Section 3.3(g), the Trustees may, in their sole discretion, determine that such Participant shall not receive his monthly Disability Benefit payments (or monthly Occupational Disability Benefit, if applicable) for up to twelve (12) months. This twelve (12)-month period shall be in addition to any period for which the Participant was not eligible to receive benefits on account of not satisfying the requirements of Subsections (a) or (b) of Section 1.41.

(h) Required Documentation:

(1) A Participant applying for a Disability Benefit or an Occupational Disability Benefit shall be required to submit a certificate of a licensed medical practitioner acceptable to the Trustees as evidence that he meets the definition of a Total and Permanent Disability or an Occupational Disability. In addition, the Participant must furnish, at the request of the Trustees, (i) an annual release whereby the Trustees may obtain Social Security Administration earnings information for any given year or years to establish proof of continued Total and Permanent Disability or Occupational Disability; and/or (ii) if the Participant has applied for a Social Security Administration Disability Benefit, copies of his application and all documentation submitted in support thereof. The Participant may also be required to submit to an examination by a physician or physicians selected by the Trustees and may be required to submit to re-examination periodically as the Trustees may direct.

(2) Any Participant who applies for a Social Security Disability Benefit shall submit to the Fund Office copies of any decision issued by the Social Security Administration immediately upon his receipt of such decision. In the event the Social Security Administration denies the Participant's application for a Social Security Administration Disability Benefit, the Participant must submit to the Fund Office a copy of the Social Security Administration's denial along with any written appeal of that adverse determination, if any.

(3) Notwithstanding any other provision of Section 1.41 or Section 3.3, if the Participant has been awarded a Social Security Administration Disability Benefit, disability recertification may be required once every two (2) years. If the Participant has not been awarded a Social Security Disability Benefit, he may be required to obtain a physician's verification of continued disability at least once each year.

(i) Notwithstanding any contrary language contained in the Plan, as described in the original and updated Rehabilitation Plans, the Disability Benefit and Occupational Disability Benefit are eliminated for any Participant who becomes subject to the terms of the Default Schedule or the

Alternate Schedule. This provision shall apply to any Participant who submits an application to the Fund Office on or after the date an Employer becomes subject to the Default Schedule or the Alternate Schedule, regardless of the date the disability was incurred.

Central Laborers' Pension Fund

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Relative Value of Benefit Payment Options for the Central Laborers' Pension Fund

The Central Laborers' Pension Fund (the "Plan") offers several optional forms of payment to eligible participants, in addition to the normal form of payment available under the Plan. These optional forms of payment have relatively the same value as the normal form of payment, except certain cases as described below. The remainder of this notice explains why you need to know this, what this means, and how this was determined.

What is "Relative Value"?

Relative value means the actuarial present value of each optional form of payment compared to the actuarial present value of the normal form of payment under a plan. Actuarial values of benefits are determined using:

- Mortality assumptions, which are based on standardized tables developed by actuarial organizations and life insurance companies. Information is analyzed about large groups of people to project the rates at which groups of individuals at different ages are expected to die. These statistical mortality projections are used to develop "average life expectancies".

- Interest assumptions, which estimate the likely investment earnings, over time, of the money put aside to pay benefits. This is important in the determination of actuarial value because investment earnings provide some of the money used to pay benefits.

What are the Relative Values under the Central Laborers' Pension Fund?

Under the Central Laborers' Pension Fund, the normal forms of payment are the:

- 50% Joint and Survivor Spousal Pension, with a pop-up feature (Qualified Joint and Survivor Annuity, QJSA), for married participants

- Life Only Pension for single participants

The generally available optional forms of payment covered by this comparison are the:

- Life Only Pension, for married participants only

- 75% and 100% Joint and Survivor Spousal Pensions (with pop-up feature), for married participants only

- Partial Lump Sum (may be combined with a Life Only or any Joint and Survivor Spousal Pension)

- Level Income Option, assuming Social Security benefits start either at age 62 or at Social Security Retirement Age, not available to disabled participants

With the exceptions listed below, all forms of payment available under the Plan have approximately the same actuarial present value of the normal form:

- For married participants retiring at age 57 or younger, the value of the Partial Lump Sum and Level Income Option exceed 105% of the value of the QJSA normal form.

Ratio of the Present Value of the Optional Forms of Payment to the QJSA for Married Participants

Commencement Age	Level Income Option	Partial Lump Sum
53	**106.4%**	**106.4%**
56	**105.5%**	**105.5%**
57	**105.2%**	**105.2%**
58	**Actuarially Equivalent**	**Actuarially Equivalent**
60	**Actuarially Equivalent**	**Actuarially Equivalent**
63	**Actuarially Equivalent**	**Actuarially Equivalent**
65	**Actuarially Equivalent**	**Actuarially equivalent**

How Was This Determined?

The valuation and reporting methodologies used were based on IRS regulations, which can be found in Treasury Regulations Section 1.417(a)(3)-1. These methodologies are fairly technical and can be difficult to understand. However, IRS regulations require the Plan to provide this information to you.

The values were calculated, for comparison purposes, assuming the Fund would earn 7.0% interest and that, on average, participants and spouses would live as long as predicted under the 1971 Group Annuity Mortality Table, and the 1965 Railroad Retirement Board All Disabled Ultimate Mortality Table for disabled participants. The Plan also assumed for married participants that the spouse is the same age as the participant.

For the Partial Lump Sum and Level Income options, the Plan used the applicable IRS yield curve rate of 2.09% for the first five years, 3.00% for the next fifteen years and 3.61% thereafter, and the 2020 Lump Sums Unisex Mortality Table, as required by the IRS regulation.

What Does This Mean to Me?

As stated earlier, basically, this means most of the optional forms of payment have relatively the same value as the normal form of payment under the Plan. However, it is important that you realize that this is not a guarantee or even a prediction of what you will actually be eligible to receive when you retire. The actual value of the different forms of payment will vary depending on how long the individual and spouse or beneficiary in fact live and on their ages when payments start.

Upon your written request, you will be provided with a similar comparison, based on your own age and estimated benefits, between your normal form of payment and on any other forms of payment that you are eligible to elect. You may want to consult a financial advisor when you are nearing retirement to determine what is right for you.

For pension starting dates during the Plan Year beginning January 1, 2020.

Central Laborers' Pension Plan
Delaying the Date Your Pension Starts Could Affect Your Benefit Amount

Regular Pension: If you are a Plan Participant and leave Covered Employment to retire on or after age 63 with at least 5 Years of Vesting Service, you are eligible for an unreduced Regular Pension. The Regular Pension is calculated based on the years in which you earned your benefit service and the number of years of benefit service. You will find instructions about how to estimate your monthly pension benefit on pages 17-18 of the Summary Plan Description and any subsequent announcement letters.

Service Pension: If you entered the Plan before January 1, 2009, you are eligible for a Service Pension as explained on page 18 of the Summary Plan Description if you retire with at least 30 Pension Credits earned before October 1, 1999. If you earn your 30th Pension Credit on or after October 1, 1999, you will receive the portion of your Service Pension earned on and after October 1, 1999 as early as age 53 as long as you satisfy one of the following requirements:

(1) earned at least one-half of a Year of Vesting Service in each of the two preceding Plan Years immediately before the Plan Year in which you reached age 53, or leave Covered Employment to retire, whichever is later, or

(2) earned at least one and one-half Years of Vesting Service during the two Plan Years before and the Plan Year you reach age 53 or leave Covered Employment to retire, whichever is later, or

(3) received an Occupational Disability Benefit continuously from your date of disability through the date your Service Pension starts and must have met one of the service requirements of (1) or (2) above when you last worked in Covered Employment.

If you entered the Plan on or after January 1, 1997 and before September 30, 1999, or re-entered the Plan on or after January 1, 1997 and before September 30, 1999 after incurring a Permanent Break in Service, you are eligible for the Service Pension earned as of September 30, 1999, regardless of age, if you have 25 Years of Vesting Service. If you earn your 25th Year of Vesting Service on or after October 1, 1999, you will receive the portion of your Service Pension earned on and after October 1, 1999 as early as age 53 as long as you satisfy one of the service requirements of (1) or (2) above when you last worked in Covered Employment.

The Service Pension is calculated the same as a Regular Pension with no reductions for age.

Since the Plan was certified in the critical status for 2011, the Trustees adopted an update of the Rehabilitation Plan in November 2013. Effective March 1, 2014:

- If your employer adopts the default or alternate schedule, you will not be eligible for a Service Pension.

- If your employer adopts the preferred schedule, you will be eligible for a Service Pension only if you have earned 30 Pension Credits and attain age 58 before leaving Covered Employment to retire.

- If your employer has not yet adopted any one of the updated schedules of the Rehabilitation Plan when you retire, you may still receive the Service Pension under the prior terms of the Plan. However, once your employer adopts one of the schedules, your benefit will be calculated

according to the new terms with retroactive effect back to March 1, 2014. Any overpaid benefits will be recouped through temporary reduction of your future monthly benefit payments.

Early Retirement Pension: If you leave Covered Employment to retire between ages 53 and 63 with at least 5 Years of Vesting Service, you may be eligible for a reduced Early Retirement Pension, as explained on page 18 of the Summary Plan Description. The Early Retirement Pension reduction factors are shown in *Appendix*, *Chart 1*, on page 45 of the Summary Plan Description.

Example of a reduced Early Retirement Pension:

Mark is retiring at age 57 with 10 Years of Vesting Service. His Regular Pension is calculated to be $1,000 per month. Because Mark is retiring six years before his Regular Pension age of 63, his monthly Early Retirement Pension will be $633.00 per month, which is $1,000 multiplied by 63.3% (the early retirement reduction factor for age 57, per *Appendix*, *Chart 1*).

Delaying Retirement Will Increase your Pension. If you delay starting your pension and continue to work in Covered Employment, your pension will increase because you are earning additional benefits. In addition, if you are eligible for a Deferred Pension that is subject to reduction for early payment, your pension will also increase the closer you are to age 65 before starting your pension.

Under the terms of the updated Rehabilitation Plan adopted by the Trustees in November 2013, effective February 1, 2014, you will be eligible for the Early Retirement Pension only if your employer adopts the preferred schedule.

Deferred Pension: If you terminate Covered Employment with at least 5 Years of Vesting Service and are not eligible for any of the one of the Pensions described above, you may be eligible for a Deferred Pension starting at age 65 as described on page 19 of the Summary Plan Description. The Deferred Pension reduction factors are shown in *Appendix*, *Chart 2*, on page 46 of the Summary Plan Description.

If your Annuity Starting Date is after your Normal Retirement Age, then your monthly benefit will be actuarially increased for each month after your Normal Retirement Age that you do not receive your pension (and you are not in Industry Employment).

Example of a Deferred Pension:

George worked in Covered Employment from age 30 to age 35 and earned 5 Years of Vesting Service. He then pursued a career as a computer technician and did not return to Covered Employment. When George reaches age 65, he will be entitled to a Deferred Pension based on the accrual rate during the years in which he earned his benefit service. If George waits until after age 65 to receive his Deferred Pension, his benefit will be actuarially increased to account for the delay.

If you have any questions about this information, please review your Summary Plan Description booklet or contact the Fund Office at 800-252-6571.