



MINNESOTA & NORTH DAKOTA
BRICKLAYERS & ALLIED CRAFTWORKERS
PENSION FUND
C/O Zenith Administrators
PO Box 257
Minneapolis, MN 55440-0257
(651) 256-1801

APPLICATION FOR RETIREMENT BENEFITS

1. What type of Pension Benefit are you applying for? Normal Early Disability
Age 65 or over Age 55-64 Age waived

2. Name (Last, First, Middle) _____

3. Telephone No. _____

4. Address _____

5. Date of Birth _____ 6. Social Security Number _____

7. Spouse's Name _____ 8. Date of Birth _____

9. Spouse's Social Security Number _____

10. What month/year do you wish your pension benefits to begin? _____

11. Last month/year you will/did work as a member of Bricklayers Local 1: _____

12. When did you first become employed on a job that is covered by an Agreement with Local 1? _____

13. When did you first join Bricklayers Local 1? _____

14. Have you ever been a member of another Local or Chapter other than Local 1? Yes No
(Please be specific of the jurisdiction or trade: i.e. Terrazzo Worker)

From _____ to _____ Local _____

From _____ to _____ Local _____

15. Have there been any periods when you left employment as a member of Bricklayers Local 1, withdrew from membership, or transferred out of the jurisdiction of Local 1? Yes No (if Yes, please specify)

From _____ to _____ Reason _____

16. Have you ever collected Workers' Compensation Benefits while working under Local 1? Yes No
(If yes, fill in the information below)

Name of Employer at that time _____ Benefits Paid from ____ to ____

Name of Employer at that time _____ Benefits Paid from ____ to ____

Name of Employer at that time _____ Benefits Paid from ____ to ____

17. Have you ever served in the Armed Forces? Yes No (If Yes, please specify)

Branch	Date Entered	Date of Discharge
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18. IF YOU ARE APPLYING FOR A DISABILITY PENSION, PLEASE COMPLETE THE FOLLOWING:

A. Have you applied for Social Security Disability Benefits? Yes No
(If you have been granted Social Security Benefits, attach a copy of your award letter)

B. Nature of your disability _____

C. When did you first become disabled? _____

D. Name and Address of your doctor _____

E. Date of your most recent examination _____

F. Have you worked at any occupation since you became disabled? Yes No
(If yes, describe your work periods)

From ____ To ____ Monthly Earnings _____

Employer _____ Type of Work _____

I HEREBY APPLY FOR A PENSION BENEFIT FROM THE TWIN CITY BRICKLAYERS PENSION FUND. THE FOREGOING STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT A FALSE STATEMENT MAY DISQUALIFY ME FOR PENSION BENEFITS, AND THAT THE TRUSTEES SHALL HAVE THE RIGHT TO RECOVER ANY PAYMENTS MADE TO ME BECAUSE OF A FALSE STATEMENT.

Signature

Date