Southern Illinois Electrical Retiree Welfare Fund

www.svcctr.org
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Toll Free 877/281-2430

APPLICATION FOR RETIREE WELFARE BENEFITS

Participant Classification (please check one)

_____ Inside _____ Outside/Tree Trimmer _____ Vistra _____ SCIRA _____ Utility

Undersigned participant states that he or she satisfies (or will shortly satisfy) the following requirements for retiree welfare benefits from the Southern Illinois Electrical Retiree Welfare Plan, applicable to the above selected classification, namely:

1. Participant has retired from any type of work in the electrical industry;

2. Participant is age 60 or older;

3. Participant has completed 20 years of service under Local 702, IBEW agreements with private employers or under representation by Local 702 with public employers, as these terms are defined in the plan document of Southern Illinois Electrical Retiree Welfare Plan; and

4. At least two years of service during the last five years meet the requirements under the plan document for work with private employers under Local 702 agreements.

Participant is eligible for continuation of medical benefits coverage with the following benefit plan:

_____

_____

(Name and Address of Participant's Medical Plan)

Participant understands that the monthly benefit payment from the Southern Illinois Electrical Retiree Welfare Plan, will be paid to the medical plan listed immediately above, as a partial payment of the self-pay premium due to that medical plan for continuation coverage for medical benefits for the applicant. If the participant does not pay any additional self-pay premium required by that medical plan, or for any other reason, does not remain eligible for medical benefits from that plan, benefits from this plan will not be paid.

(over)

Participant Contact Information

_____	XXX-XX-_____
Participant Name	Social Security Number (last 4 digits)
_____	_____
Address	Participant Date of Birth
_____	_____
Participant's Last Employer	Participant Retirement Date
_____	_____
Participant Telephone Number	Participant Email Address
_____	_____
Spouse's Name	Spouse's Date of Birth

Required Documentation - marriage license (if applicable) and birth certificate for both Participant and Spouse

Participant has a current copy of Summary Plan Description of this plan and has read the sections relating to eligibility years of years of service for private employers, years of service for a public employer and return to work.

Participant understands that benefits will terminate during any month when participant is actively working in the electrical industry. Participant agrees **TO IMMEDIATELY NOTIFY THE FUND OFFICE IN WRITING** if returning to work in the electrical industry; a new application for benefits must be filed if the undersigned again retires from such work.

Participant has read this application form. Participant understands eligibility rules and benefit amounts may be changed by the Trustees, along with other changes in the plan documents. Such changes may include a reduction or termination of benefits.

Signed this _____ day of _____, 20_____

_____
Participant Signature

Plan Verification of Eligibility Requirements

Participant satisfies all eligibility requirements for plan benefits: YES _____ NO _____

If NO – please see denial letter indicating denial in whole or in part

_____
Plan Authorized Signature