THE UMWA Health and Retirement FUNDS

# PENSION APPLICATION

***Complete this Application for all Types of Pension Benefits***

**ALL APPLICATIONS FOR PENSION BENEFITS SHOULD BE SENT TO:**

**UMWA Health and Retirement Funds**
**2121 K Street NW  Suite 350**
**Washington DC  20037-1879**
**1-800-291-1425**
**Fax: 202-521-2353**
**E-mail: Pension@umwafunds.org**

THE UMWA Health and Retirement FUNDS

# PENSION APPLICATION

**SERVICE PENSION**—Mine workers may qualify for a service (retirement) pension if any of the following (1, 2, 3, 4, or 5) describe your situation:

1. You last worked on or after December 31, 1975, are at least 55 years old, and
   a. have 10 years signatory service, OR
   b. have 5 years signatory service if you last worked on or after December 16, 1993 for a Normal Pension, or July 1, 1999 for a Deferred Vested Pension.
2. You last worked on or after January 1, 1998, have 20 years of signatory service, and were permanently laid off.
3. You last worked on or after January 1, 2002, have 30 years of signatory service, and were laid off during 2002.
4. You have 30 years of signatory service and stopped working after January 1, 2003.
5. You last worked before December 31, 1975 and
   a. have 10 years signatory service after May 28, 1946, including at least 3 years after December 31, 1970, OR
   b. have 20 years credited service, including a minimum of 5 to 10 years signatory service.

**DISABILITY PENSION**—There are no age or service requirements for a disability pension. However, you must fill out the special disability pension section of this application.

**SURVIVING SPOUSE PENSION**—The 1974 Pension Plan provides monthly pension payments to the eligible surviving spouse of a mine worker who died while receiving, or while eligible to receive, a pension from the 1974 Pension Plan. In addition, the 1974 Pension Plan provides monthly payments to the surviving spouses of certain mine workers who met the service requirements for a pension but died after August 23, 1984 before attaining age 55.

If the deceased mine worker had not applied for a Funds' pension, use this application to apply for a 1974 Pension Plan Surviving Spouse benefit. You must complete all sections of the application and provide all of the information requested about both you and the deceased mine worker. Be sure to include with the application: copies of your (1) marriage certificate (2) divorce decree(s), if applicable, and (3) the mine worker's birth and death certificates.

# Pension Application Checklist

## All applicants must remember to:

- ☐ **Attach mine worker's birth certificate. (clear copies are acceptable)**
- ☐ **Attach spouse's birth certificate. (clear copies are acceptable)**
- ☐ **Attach marriage certificate(s). (clear copies are acceptable)**
- ☐ **Attach copies of divorce decree(s) <u>including any marital property settlements</u>, if applicable, and any Qualified Domestic Relations Order(s) (QDRO's).**
- ☐ **Attach documents proving UMWA service, Workers' Compensation, or Military time.**
- ☐ **Complete the Number Holder's Information section of the Authorization to Obtain Earnings from SSA *only* if you worked prior to April 1976. Please leave the Periods Requested section blank. Return this form with your application. The Funds will complete the remaining sections and send the form to SSA.**
- ☐ **Sign the application on page 6 when complete. Be sure to sign your name in each shaded box of the application.**

## If applying for a Disability Pension you must also remember to:

- ☐ **Complete all pages of this application, including the 3 Authorizations for Medical Records.**
- ☐ **Attach all Workers' Compensation paperwork.**
- ☐ **Attach a copy of your Accident Report(s).**
- ☐ **Attach Social Security Award letter and Admnistrative Law Judge (ALJ) decision, if applicable.**

## If applying for a Surviving Spouse Pension you must also remember to:

- ☐ **Attach a copy of the mine worker's death certificate.**

THE UMWA Health and Retirement FUNDS

# Pension Application

***Check the type of pension you are applying for (please check only ONE box):***

❑ SERVICE ❑ DISABILITY ❑ BENEFIT STATEMENT
❑ 30/OUT ❑ QDRO ❑ SURVIVING SPOUSE (MW not a Pensioner)
❑ SPECIAL PERMANENT LAYOFF

## Information About the Mine Worker

| Name (Last, First, Middle) | | Social Security Number (required) |
|---|---|---|
| Address | | Area Code & Telephone Number ( ) |
| City State Zip | | Date of Birth (Attach a copy of birth certif.) |
| E-mail Address | Alternate Phone Number ( ) | Date of Death (Attach a copy of death certif.) |

Was the mine worker killed in a mine accident? ❑ YES ❑ NO

## Information About the Mine Worker's Spouse or Alternate Payee (QDRO)*

Current Marital Status

❑ Married ❑ Never Been Married ❑ Separated ❑ Divorced ❑ Common-Law Marriage

(Attach copy of Divorce Decree or QDRO, if applicable)

| Name (Last, First, Middle) Relationship | | Area Code & Telephone Number ( ) |
|---|---|---|
| Address City State Zip | | |
| Social Security Number (required) | Date and Place of Marriage (City, State) (Attach copy of your marriage certif.) | Date of Birth (Attach a copy of birth certif.) |

Were you married to the mine worker at time of death? ❑ YES ❑ NO
Were you living with the mine worker at time of death? ❑ YES ❑ NO
} For Surviving Spouse Application

## Information About the Mine Worker's Marriage(s)

Answer this item ONLY if the mine worker had other marriages, including common law marriages. (If none, write "NONE.") Please provide actual dates, if known. If dates are approximate, please circle them.

| Spouse's Name *(Including maiden name)* | When *(Month, Day, and Year)* | Where *(Name of City and State)* |
|---|---|---|
| How Marriage Ended | When *(Month, Day, and Year)* | Where *(Name of City and State)* |
| ❑ Legal Marriage<br>❑ Common Law Marriage | Spouse's date of birth *(or age)* | If spouse deceased, give date of death |

Spouse's Social Security Number *(If none or unknown, so indicate)* _____

**If necessary, attach a separate sheet of paper with this same information about any other marriages of the deceased.**

*Qualified Domestic Relations Order

## Last Coal Industry Employment – Date you began working in the coal industry _____.

Are you now working in the coal industry? If "NO," give last date worked in the industry; If "YES," give approximate date you plan to retire:

❑ YES ❑ NO _____/_____/_____ _____

MONTH DAY YEAR COMPANY NAME

Why did you stop working?

❑ LAID OFF ❑ RETIRED ❑ DISABLED (*explain below)* ❑ OTHER (*explain below)*

Please describe your disability or provide the reason that you stopped working:

## Mine Worker's Employment History *(Union/Non-Union)* – Please list all coal employment to ensure credit is awarded appropriately.

*If you need more space than is provided in this section, use sheets of plain paper and attach them to this application.*

| FROM mo/year | TO mo/year | COMPANY'S NAME | MINE ADDRESS (CITY AND STATE) | MINE NAME | LOCAL UNION | JOB CLASSIFICATION |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Other Sources of Credit – Please complete all sections that apply to ensure all possible credit is considered.

*Complete this section if you have received income or benefits from any of the other sources of credit listed below. Please mark the ones that apply and give the information requested. Be sure to include proof of your service, such as copies of benefit awards, military discharge papers, and UMWA employment statements.*

| SOURCE OF CREDIT | | FROM* | TO* |
|---|---|---|---|
| WERE YOU . . .<br>A) EMPLOYED BY THE UMWA? (DISTRICT OR INTERNATIONAL) | YES ❑ NO ❑ | | |
| B) A MEMBER OF THE MILITARY SERVICE? (ONLY IF MILITARY SERVICE OCCURRED DURING YOUR COAL EMPLOYMENT) | YES ❑ NO ❑ | | |
| HAVE YOU RECEIVED (ARE YOU RECEIVING)<br>A) SICKNESS AND ACCIDENT BENEFITS?<br>❑ YES ❑ NO | 1ST PERIOD | | |
| | 2ND PERIOD | | |
| B) WORKERS' COMPENSATION FOR MINE-RELATED INJURY OR OCCUPATIONAL DISEASE?<br>❑ YES ❑ NO | 1ST PERIOD | | |
| | 2ND PERIOD | | |

*month/year

## Applicant's Certification

**I certify that all of the information on this application is true and correct. I understand that if any of the information is false, and that if I then receive benefits because of false information, I shall have to repay the benefits to the Funds. I also understand that if I have deliberately given false information, the Funds may take legal action against me.**

_____ _____

**Applicant's signature required** **Date**

**Please be sure to sign above to avoid any unnecessary delays in processing. Thank you.**

Social Security Administration

Form Approved
OMB No. 0960-0602

# Authorization to Obtain Earnings Data from the Social Security Administration

| | | | |
|---|---|---|---|
| Mail completed form to: | Social Security Administration<br>PO Box 33011<br>Baltimore, MD 21290-3011 | Requesting organization: | SSA Job No 8918 Index 1<br>THE UMWA HEALTH & RETIREMENT FUNDS<br>2121 K ST NW STE 350<br>WASHINGTON DC 20037 |

## Number Holder's Information

First Name: Middle Initial:

Last Name:

SSN: -- --

Date of Birth: -- -- (Month Day Year) Date of Death: -- -- (Month Day Year)

Other First, Middle Initial, and Last Name Used to Report Earnings:

Year(s) Requested: (Y Y Y Y) through (Y Y Y Y)

(Y Y Y Y) through (Y Y Y Y)

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

| | |
|---|---|
| Signature of Number Holder *(or authorized representative)* | Date -- -- (M M D D Y Y Y Y) |
| Printed Name *(if other than number holder)* | Relationship *(if other than number holder)*<br>☐ Spouse<br>☐ Legal Representative<br>☐ Other *(specify)* |
| Address / State | |
| City / ZIP Code | Phone Number |

## Requesting Organization's Information

*SSA must receive this form within 60 days from the date signed by the Number Holder (or Authorized Representative)*

| | |
|---|---|
| Signature of Organization Official | Date |
| Phone Number | Fax Number |

**FOR SSA USE ONLY** ☐1 ☐2 ☐3 ☐4

Form **SSA-581-OP134** (11-2014)

# IMPORTANT INFORMATION

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

Section 205(c)(2)(A) of the Social Security Act, as amended, authorizes us to collect this information. We will use the information you provide to obtain earnings data. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed. We rarely use the information you supply us for any purpose other than to produce an itemized statement of earnings. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0059, entitled, Earnings Recording and Self-Employment Income System. Additional information about this and other system of records notices and our programs is available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

**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 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

THE UMWA Health and Retirement FUNDS

# Federal Income Tax Withholding Election

*Whether or not federal income tax will be withheld from your pension check is your decision. Please read the two choices listed below and indicate your decision.* ***Check only one box (A or B).***

*If you check B, please check marital status and list the number of exemptions for your tax purposes.*

A. ❑ I DO NOT WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY MONTHLY PENSION CHECK.

B. ❑ I WANT TO HAVE FEDERAL INCOME TAX WITHHELD FROM MY MONTHLY PENSION CHECK ON THE FOLLOWING BASIS *(Please check* ***only one box):***

❑ MARRIED ❑ SINGLE

NUMBER OF EXEMPTIONS _____

Also, I want to have the following amount withheld from my monthly pension check **in addition to** the amount calculated using the number of exemptions listed above: $_____.

MINE WORKER'S SOCIAL SECURITY NUMBER (required) _____

SPOUSE OR ALTERNATE PAYEE'S SOCIAL SECURITY NUMBER (required) _____

_____ _____

**APPLICANT'S SIGNATURE (required)** **DATE**

THE UMWA Health and Retirement FUNDS

# Beneficiary Designation Form

***Certain mineworker pensions may be eligible for a lump sum death benefit payment. This form allows mineworkers to name the person that they want to receive the death benefit.***

MINE WORKER NAME: _____

SOCIAL SECURITY NUMBER (required): _____

*Please print the following information for your primary beneficiary:* ***Please note that the death benefits cannot be split among several beneficiaries. Please name only one primary and one contingent beneficiary.***

NAME OF PRIMARY BENEFICIARY (FIRST, MIDDLE INITIAL, LAST) (NAME ONLY ONE)

RELATIONSHIP

SSN OR EIN OF PRIMARY BENEFICIARY **(Required)**

ADDRESS OF PRIMARY BENEFICIARY

CITY, STATE, ZIP CODE OF PRIMARY BENEFICIARY

TELEPHONE NUMBER ( )

FAX NUMBER ( )

E-MAIL ADDRESS

*Please print the following information for your contingent beneficiary. The contingent beneficiary will receive the death benefit only if the beneficiary named above dies before you.*

NAME OF CONTINGENT BENEFICIARY (FIRST, MIDDLE INITIAL, LAST) (NAME ONLY ONE)

RELATIONSHIP

SSN OR EIN OF CONTINGENT BENEFICIARY **(Required)**

ADDRESS OF CONTINGENT BENEFICIARY

CITY, STATE, ZIP CODE OF CONTINGENT BENEFICIARY

TELEPHONE NUMBER ( )

FAX NUMBER ( )

E-MAIL ADDRESS

*This form must be signed by the mine worker and must bear the signature of a witness. If the form is signed by any other individual, a copy of the document authorizing that individual to act on the mine worker's behalf (power of attorney or guardianship paper) must accompany this form. If signed by POA, the Power of Attorney document must specifically indicate that the POA has the right to designate a beneficiary.*

SIGNATURE (required): _____ DATE: _____

WITNESS SIGNATURE (required): _____ DATE: _____

THE UMWA Health and Retirement FUNDS

# Enrollment for Pension Payment by Electronic Funds Transfer

I authorize the UMWA 1974 Pension Plan and the financial institution listed below to deposit my pension payment electronically into my account each month. If monies to which I am not entitled are deposited into my account, I authorize the Plan to direct my financial institution to return said funds. This authority will remain in effect until I have cancelled it in writing.

Name

Payee Social Security Number (required)

Mine Worker SSN
*(if different than Payee SSN above)*

Financial Institution

Branch Address

City, State, Zip

Payee Street Address: _____
City State Zip

(_____)
(Area Code) Phone Number

Signature (required)

Date

❑ Checking ❑ Savings
*(Check one type of account)*

Account Number

(_____)
Bank Phone Number

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Transit Routing Number (ABA*)

**ATTACH VOIDED PERSONAL CHECK OR DEPOSIT SLIP HERE**

# COMPLETE THESE LAST 3 PAGES ONLY IF YOU ARE APPLYING FOR A DISABILITY PENSION

Please list all mine accidents that contributed to your disability. If you need more space, write them on a separate sheet and attach them to this application.

To qualify for a disability pension, you must be receiving Social Security Disability Insurance Benefits and your disability must have been caused by a mine accident that happened while you were working in a classified job for a signatory employer. The disability must meet three requirements: **1) Unexpectedness:** The disability must have been unlooked for and unforeseen; **2) Definiteness:** The disability must be traceable to a definite time, place and occasion (a progressive disease does not meet this test); and **3) Force or impact:** The disability must have been caused by the exertion or impact of some external physical force or object against the body or by the exertion or impact of the body against some external physical object.

## Social Security

ARE YOU RECEIVING SOCIAL SECURITY DISABILITY BENEFITS? IF YES, ATTACH A COPY OF YOUR AWARD LETTER. ❑ YES ❑ NO

## Disability Information

### FIRST CLAIMED ACCIDENT

HAVE YOU RECEIVED WORKERS' COMPENSATION FOR THIS INJURY? IF YES, ATTACH A COPY OF YOUR INJURY REPORT AND AWARD LETTER. ❑ YES ❑ NO

| DATE OF ACCIDENT | COMPANY NAME | MINE WHERE INJURED |
|---|---|---|
| TYPE OF INJURY | JOB CLASSIFICATION | |

PLEASE DESCRIBE HOW INJURY OCCURRED.

### SECOND CLAIMED ACCIDENT

HAVE YOU RECEIVED WORKERS' COMPENSATION FOR THIS INJURY? IF YES, ATTACH A COPY OF YOUR INJURY REPORT AND AWARD LETTER. ❑ YES ❑ NO

| DATE OF ACCIDENT | COMPANY NAME | MINE WHERE INJURED |
|---|---|---|
| TYPE OF INJURY | JOB CLASSIFICATION | |

PLEASE DESCRIBE HOW INJURY OCCURRED.

### THIRD CLAIMED ACCIDENT

HAVE YOU RECEIVED WORKERS' COMPENSATION FOR THIS INJURY? IF YES, ATTACH A COPY OF YOUR INJURY REPORT AND AWARD LETTER. ❑ YES ❑ NO

| DATE OF ACCIDENT | COMPANY NAME | MINE WHERE INJURED |
|---|---|---|
| TYPE OF INJURY | JOB CLASSIFICATION | |

PLEASE DESCRIBE HOW INJURY OCCURRED.

**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.
- 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).*

**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: |
|---|---|
| UNITED MINE WORKERS OF AMERICA | 2121 K STREET NW ste 350 |
| ATTN: Disability Specialist | Washington DC 20037 |

***I want this information released because:** _____

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ 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 **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   831's, 833's, ALJ DECISIONS. IF FILE IS DESTROYED OR CANNOT BE LOCATED, PLEASE NOTE IN A LETTER AND STATE THE ONSET DATE AND ALL DIAGNOSES FOR WHICH SSDI WAS AWARDED.

**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 any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain 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:** _____

**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 (required) | 2.Signature of witness (required) |
|---|---|
| Address(Number and street,City,State, and Zip Code) | Address(Number and street,City,State, and Zip Code) |

**Form SSA-3288** (07-2013) EF (07-2013)

# UMWA HEALTH AND RETIREMENT FUNDS

## Authorization for Medical Records General

# A U T H O R I Z A T I O N

Date: _____

Mineworker Name: _____

Mineworker SSN (required): _____

Date Last Worked: _____

Type of Disability: _____

Date of Injury(ies): _____

To Whom It May Concern:

I have filed an application for a disability pension with the United Mine Workers of America Health and Retirement Funds. In order to determine whether I am eligible for this pension, the Funds needs additional information about the circumstances under which I became disabled. The Funds also needs to know whether I have received Workers' Compensation or Sickness and Accident benefits for my disability, and, if so, the medical evidence upon which the benefit awards were based.

*Please provide the Funds with the requested information as soon as possible.*

Signature (required): _____

Date: _____