



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**

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.**
- ☐ **Attach spouse's birth certificate.**
- ☐ **Attach marriage certificate(s).**
- ☐ **Attach divorce decree(s), 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 Administrative 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.**

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
☐ SPECIAL PERMANENT LAYOFF (MW not a Pensioner)

Information About the Mine Worker

Name (Last, First, Middle)		Social Security Number
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? <input type="checkbox"/> YES <input type="checkbox"/> 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	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? <input type="checkbox"/> YES <input type="checkbox"/> NO Were you living with the mine worker at time of death? <input type="checkbox"/> YES <input type="checkbox"/> 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)
<input type="checkbox"/> Legal Marriage <input type="checkbox"/> 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*
<u>WERE YOU ...</u>	YES NO		
A) EMPLOYED BY THE UMWA? (DISTRICT OR INTERNATIONAL)	<input type="checkbox"/> <input type="checkbox"/>		
B) A MEMBER OF THE MILITARY SERVICE? (ONLY IF MILITARY SERVICE OCCURRED DURING YOUR COAL EMPLOYMENT)	YES NO <input type="checkbox"/> <input type="checkbox"/>		
<u>HAVE YOU RECEIVED</u> (ARE YOU RECEIVING)			
A) SICKNESS AND ACCIDENT BENEFITS?	1ST PERIOD		
<input type="checkbox"/> YES <input type="checkbox"/> NO	2ND PERIOD		
B) WORKERS' COMPENSATION FOR MINE-RELATED INJURY OR OCCUPATIONAL DISEASE?	1ST PERIOD		
<input type="checkbox"/> YES <input type="checkbox"/> NO	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_____
Date**Please be sure to sign above to avoid any unnecessary delays in processing. Thank you.**

Mail completed form to:	Social Security Administration Division Business Services PO Box 33011 Baltimore, MD 21290-3011	Requesting organization:	RA PENF 09 8918 THE UMW HEALTH & RETIREMENT FUNDS 2121 K ST NW STE 350 WASHINGTON DC 20037
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First Name:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Middle Initial:	<input type="text"/>										
Last Name:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>												
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Date of Birth:	<input type="text"/> <input type="text"/>	--	<input type="text"/> <input type="text"/>	--	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of Death:	<input type="text"/> <input type="text"/>	--	<input type="text"/> <input type="text"/>	--	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
	Month		Day		Year		Month		Day		Year		
Other First, Middle Initial, and Last Name Used to Report Earnings:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>											<input type="text"/>	
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	Month		Year		Month		Year						

Signature of Number Holder <i>(or authorized representative)</i>		Date	<div><div></div><div></div></div> -- <div><div></div><div></div></div> -- <div><div></div><div></div><div></div><div></div></div>
Printed Name <i>(if other than number holder)</i>		Relationship <i>(if other than number holder)</i>	
Address		<input type="checkbox"/> Natural or adoptive parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other <i>(specify)</i> _____	
State	City	ZIP Code	Phone Number

Signature of Organization Official		Date
Phone Number	Fax Number	

1 2 3 4



IMPORTANT INFORMATION

Privacy Act Statement

SSA 581 (Authorization to Obtain Earnings Data from the Social Security Administration)

Sections 205(a), 205(c)(2), and 223 of the Social Security Act, as amended, authorize us to collect the information requested on this form. We will use the information you provide to obtain your earnings data or the earnings data of a deceased individual. Your responses are voluntary. However, failure to provide us with the requested information could prevent us from processing your request.

We rarely use the information you give us for any purpose other than providing the earnings information you request. However, we may use the information for the efficient administration of our programs. We may also disclose information to another person or agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, the Department of Justice, and the Department of Treasury);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you give us in 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.

A complete list of routine uses of the information you gave to us is available in our Privacy Act System of Records Notice entitled, Earnings Recording and Self-Employment Income System, 60-0059. Additional information about this and other systems of records notices and our programs are available from our Internet website at 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 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.***

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 _____

SPOUSE OR ALTERNATE PAYEE'S SOCIAL SECURITY NUMBER _____

APPLICANT'S SIGNATURE

DATE



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: _____

*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 you to act on the mine worker's behalf (power of attorney or guardianship paper) must accompany this form.

SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____



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

Financial Institution

Payee Social Security Number

Branch Address

Mine Worker SSN
(if different than Payee SSN above)

City, State, Zip

Payee Street Address:

City

State

Zip

()
(Area Code) Phone Number

☐ Checking
(Check one type of account)

☐ Savings

Signature

Account Number

Date

()
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.



UMWA HEALTH AND RETIREMENT FUNDS

Authorization for Release of Social Security Medical Records

Please PRINT clearly and provide all information requested.

Mineworker Name: _____ SSN: _____

Address: _____

Telephone: _____ Age: _____

Indicate the following benefits for which claims have been filed. List the month and year the claim was filed and indicate if the claim was approved or denied.

- () A claim was filed for Social Security Disability Benefits in _____,
and was () approved () denied. Month/Year
- () A claim was filed for Supplemental Security Income based on disability _____,
and was () approved () denied. Month/Year
- () A claim was filed for Federal Black Lung Benefits in _____,
and was () approved () denied. Month/Year

I hereby authorize the Social Security Administration to release to the UMWA Health and Retirement Funds copies of all medical records (including "Disability Determination and Transmittal," form SSA-831) used to process my claim for Social Security Disability Benefits, Supplemental Security Income or Federal Black Lung Benefits. I understand that this authorization expires when the Social Security Administration sends the requested records to the Funds, unless I revoke the authorization before then in writing.

Signature (or mark): _____ Date: _____

Name and Address of Witness (necessary ONLY if mark is used)

For Office Use Only

(Do not write in the space below.)

Endorsed by the UMWA Health and Retirement Funds: I hereby verify that the Funds require, for the determination of benefit eligibility under the Funds disability program, copies of records from the file of the claimant listed above. The records immediately required are:

- () All medical records used to process claim.
() All Form 831's and 833's to date.
() All existing ALJ decisions with supporting exhibits.
() Form SSA 16 F6 and SSA 3368 F8.
() Termination document with supporting evidence (furnish immediately regardless of appeal status).
() Other: _____

Please mail all records to the attention of: Manager, Records Management, UMWA Health and Retirement Funds, 2121 K Street, NW, Suite 350, Washington, DC 20037-1879.

Authorized Signature: _____ Date: _____



Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

TO: Social Security Administration

Name Date of Birth Social Security Number

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

NAME

ADDRESS

UNITED MINE WORKERS OF AMERICA
ATTN: Disability Specialist

2121 K STREET NW SUITE 350
WASHINGTON DC 20037

I want this information released because:

I AM APPLYING FOR MY DISABILITY PENSION.

Please release the following information:

- ☐ Social Security Number
☐ Identifying information (includes date and place of birth, parents' names)
☐ Monthly Social Security benefit amount
☐ Monthly Supplemental Security Income payment amount
☐ Information about benefits/payments I received from _____ to _____
☐ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
☒ Medical records
☒ Record(s) from my file (specify) 831's, 833's, ALJ DECISIONS

☒ Other (specify) IF FILE IS DESTROYED OR CAN NOT 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 information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Form SSA-3288 (5-2007) EF (5-2007)

UMWA HEALTH AND RETIREMENT FUNDS

Authorization for Medical Records General

AUTHORIZATION

Date: _____

Mineworker Name: _____

Mineworker SSN: _____

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: _____

Date: _____



