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
❑ QDRO ❑ SURVIVING SPOUSE (MW not a Pensioner)

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 ❑ 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 . . .	YES NO	Month/Year	Month/Year
A) EMPLOYED BY THE DISTRICT OR INTERNATIONAL?	❑ ❑		
B) A MEMBER OF THE MILITARY SERVICE DURING YOUR COAL EMPLOYMENT?	YES NO ❑ ❑		
HAVE YOU RECEIVED (ARE YOU RECEIVING)	1ST PERIOD		
A) SICKNESS AND ACCIDENT BENEFITS? ❑ YES ❑ NO	2ND PERIOD		
B) WORKERS' COMPENSATION FOR MINE-RELATED INJURY OR OCCUPATIONAL DISEASE? ❑ YES ❑ NO	1ST PERIOD		
	2ND PERIOD		

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.

Authorization to Obtain Earnings Data from the Social Security Administration

ail ompleted rm to:	Social Security Administration PO Box 33011 Baltimore, MD 21290-3011
Requesting organization:	SSA Job No 8918 Index 01 The UMWA Health & Retirement Funds 2121 K Street NW, Suite 350 Washington, D.C. 20037

Number Holder's Information

rst Name: Middle Initial:

ast Name:

SN: -- --

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

ther First, iddle Initial, nd Last Name sed to Report arnings:

ear(s) equested: through (Y Y Y Y)

through (Y Y Y Y)

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

ignature of Number Holder *(or authorized representative)*	Date -- -- (M M / D D / Y Y Y Y)
rinted Name *(if other than umber holder)*	Relationship *(if other than number hold* ☐ Spouse ☐ Legal Representative ☐ Other *(specify)*
ddress / State	
ity / ZIP Code	Phone Number

Requesting Organization's Information

SSA must receive this form within 120 days from the date signed by the Number Holder (or Authorized Representative)

ignature of Organization Official	Date
hone Number	Fax Number

OR SSA USE ONLY ☐1 ☐2 ☐3 ☐4

IMPORTANT INFORMATION

Privacy Act Statement
Collection and Use of Personal Information

ection 205(c)(2)(A) of the Social Security Act, as amended, allows us to collect this information. urnishing us this information is voluntary. However, failing to provide all or part of the information may revent us from furnishing detailed earnings information.

Ve will use the information to produce detailed earnings information about the wage earner. We may als hare your information for the following purposes, called routine uses:

- To employers or former employers, including State Social Security administrators, for correcting and reconstructing State employee earnings records and for Social Security purposes; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting the Socia Security Administration in the efficient administration of its programs.

n addition, we may share this information in accordance with the Privacy Act and other Federal laws. Fo xample, where authorized, we may use and disclose this information in computer matching programs, i hich our records are compared with other records to establish or verify a person's eligibility for Federal enefit programs and for repayment of incorrect or delinquent debts under these programs.

list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 0-0059, entitled Earnings Recording and Self-Employment published in the Federal Register (FR) on anuary 11, 2006, at 71 FR 1819. Additional information, and a full listing of all of our SORNs, is availab n our website at www.ssa.gov/privacy.

aperwork Reduction Act Statement - This information collection meets the requirements of 4 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need t nswer these questions unless we display a valid Office of Management and Budget (OMB) control umber. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and nswer the questions. ***Send only comments regarding this burden estimate or any other aspect of his collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, altimore, MD 21235-6401.*

THE UMWA Health and Retirement FUNDS

Federal Income Tax Withholding Election

Applicant:	MW Funds ID:
Step 1: Election	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. For tax purposes I am: ☐ Single or Married filing separately ☐ Married filing jointly or a Qualifying widow(er) ☐ Head of household *(check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)*
Complete Steps 2, 3, and 4 only if they apply to you. Do not complete these steps if you checked Box A in Step 1. Otherwise, skip these and sign the form.	
Step 2: Income From a Job and/or Multiple Pensions/ Annuities (including a spouse's)	Complete this step if you (1) receive income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. If you (and/or your spouse) have one or more jobs, then enter the total taxable **annual** pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs, less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" ▶ $_____ If you (and/or your spouse) have any other pensions/annuities that pay less annually than this one, then enter the total **annual** taxable payments from all lower-paying pensions/annuities. Otherwise, enter "-0-" ▶ $_____
Step 3: Claim Dependents and Other Credits	If your total income will be $200,000 or less ($400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by $2,000 ▶ $_____ Multiply the number of other dependents by $500 ▶ $_____ Add other credits, such as foreign tax credit and education tax credits ▶ $_____
Step 4 (optional): Other Adjustments	(a) **Other income** (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends. ▶ $_____ (b) **Deductions.** If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the IRS Deductions Worksheet and enter the result here. ▶ $_____ (c) **Extra withholding.** Enter any additional tax you want withheld from **each payment**. ▶ $_____

Signature *(This form is not valid unless you sign it.)* 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: _____