

**TEAMSTERS LOCAL # 331 BENEFIT FUNDS
SEVERANCE BENEFIT APPLICATION
AND SPECIAL TAX NOTICE**



RETURN TO:

**TEAMSTERS LOCAL 331 BENEFITS
FUNDS ADMINISTRATOR
1 PHILADELPHIA AVE.
EGG HARBOR CITY, NJ 08215
609-485-0837**

Dear Participant:

Enclosed please find your Severance Benefit Application.

You are eligible for severance benefits under the Plan if you completely withdraw from employment. You have completely withdrawn from employment if you do not work in a job covered by a Collective Bargaining Agreement requiring your Employer to make contributions to the Plan on your behalf for a least six (6) consecutive months.

For purposes of determining complete withdrawal from employment, if the only contributions made on your behalf during the six (6) months were for less than six (6) days of work, they will be treated as if no contributions were made.

We are happy to be of service to you. If you have any questions, please do not hesitate to call the Funds Administrator at 609-485-0837 for local calls or 800-533-9739 out of town.

Thank you,

JOINT BOARD OF TRUSTEES

TEAMSTERS LOCAL #331 BENEFIT FUNDS
SEVERANCE APPLICATION

NAME: _____ SS# _____

ADDRESS: _____

_____ TELEPHONE: _____

PRESENT
EMPLOYER: _____ BIRTHDATE: _____

*** IF PARTICIPANT IS DECEASED - Fill in Beneficiary's Name**

Former Employers: List below all employers you have worked for under contract.

DATE	EMPLOYER
FROM _____ TO _____	_____
FROM _____ TO _____	_____
FROM _____ TO _____	_____

• NOTE : IF ADDITIONAL SPACE IS NEEDED, PLEASE USE BACK OF FORM

I AM FULLY TERMINATED FROM EMPLOYMENT AS OF _____ AND
THE REASON FOR LEAVING _____

PLEASE READ CAREFULLY !!!!!

AN APPLICATION CONTAINING A FALSE STATEMENT OF ANY MATERIAL FACT
MAY BE DISAPPROVED. IF SUCH A FALSE STATEMENT IS DISCOVERED AFTER THE
PAYMENT OF BENEFITS HAS COMMENCED, SUCH PERSON MAY BE REQUIRED TO
RETURN TO THE SEVERANCE TRUST FUND PRIOR PAYMENT MADE TO HIM.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND THAT I
HAVE NOT BEEN EMPLOYED BY AN EMPLOYER WHO HAS CONTRIBUTED TO THE
TEAMSTERS SEVERANCE FUND ON MY BEHALF DURING THE PAST SIX (6) MONTHS.

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE OFFICE USE ONLY

CONFIRMATION OF EMPLOYMENT _____ FROM _____

**IF PARTICIPANT IS MARRIED YOU MUST COMPLETE THIS SECTION.
SPOUSAL CONSENT TO LUMP SUM DISTRIBUTION**

NAME OF PARTICIPANT: _____

PARTICIPANT SOCIAL SECURITY #: _____

I hereby swear that I am the legal spouse of the above-named participant. I consent to the distribution of my spouse's Account balance as indicated in this application.

SPOUSES'S SIGNATURE

SPOUSE'S SOCIAL SECUTIRY #

SWORN AND SUBSCRIBED TO BEFORE ME THIS _____ DAY OF _____, 20_____.

NOTARY PUBLIC

OR

PLAN REPRESENTATIVE

MY COMMISSION EXPIRES:

PARTICIPANT'S STATEMENT

I ELECT TO WAIVE RECEIPT OF MY ACCOUNT BALANCE IN THE FORM OF A QUALIFIED JOINT AND SURVIVOR ANNUITY. I UNDERSTAND THAT REJECTING THIS FORM OF BENEFIT PAYMENT MEANS THAT MY ACCOUNT BALANCE WILL NOT BE PAID TO MY SPOUSE (IF ANY) AFTER MY DEATH, UNLESS SUCH ACCOUNT BALANCE IS PAYABLE TO MY SPOUSE UNDER ANOTHER SECTION OF THE PLAN. (CHECK ONE)

_____ I HEREBY SWEAR THAT I AM NOT LEGALLY MARRIED AT THIS TIME.

_____ I HEREBY SWEAR THAT I AM UNABLE TO LOCATE MY SPOUSE. (IF YOU CHECK THIS THE PLAN MAY CONTACT YOU AND OBTAIN ADDITIONAL INFORMATION.)

_____ I HEREBY SWEAR THAT THE PERSON CO-SIGNING THIS DOCUMENT IS MY CURRENT AND LEGAL SPOUSE.

PARTICIPANT'S SIGNATURE

DATE

SWORN AND SUBSCRIBED TO BEFORE ME THIS _____ DAY OF _____, 20_____.

NOTARY PUBLIC

OR

PLAN REPRESENTATIVE

MY COMMISSIONS EXPIRES:

DISTRIBUTION

I/WE _____ ACKNOWLEDGE THAT I
HAVE RECEIVED A COPY OF THE SPECIAL TAX NOTICE REGARDING
PLAN PAYMENTS WHICH IS A PART OF MY APPLICATION AND HEREBY
ELECT THE FOLLOWING:

1. _____ * A DIRECT ROLLOVER TO MY IRA OR OTHER QUALIFIED PLAN.
2. _____ THAT THE BENEFIT BE PAID DIRECTLY TO ME IN ACCORDANCE WITH THE TAX NOTICE.
3. _____ *A DIRECT ROLLOVER TO MY IRA IN THE AMOUNT OF \$ _____ AND PAYMENT OF \$ _____ DIRECTLY TO ME.
4. _____ A MONTHLY PAYMENT OF \$ _____ FOR _____ YEARS IN ACCORDANCE WITH THE TAX NOTICE. [The last payment will equal the remaining balance in my account.] (Cannot exceed 10 years)

* NOTE: PLEASE ATTACH A COPY OF REQUIRED FORMS FROM THE FINANCIAL INSTITUTION OR PLAN.

SIGNATURE DATE

DIRECT ROLLOVER YOU MUST COMPLETE THIS SECTION.
NAME OF QUALIFIED PLAN / FINANCIAL INSTITUTION (IRA)

NAME CONTACT PERSON

STREET ADDRESS TELEPHONE

CITY, STATE, ZIP CODE

* ANY SPECIAL INSTRUCTIONS _____

APPROVED BY PLAN ADMINISTRATOR DATE