



North Atlantic States Carpenters
Annuity Fund

Connecticut Office
10 Broadway
Hamden, CT 06518
www.carpentersfund.org
Phone: 203-281-5511
Fax: 203-230-2457

Rhode Island Office
14 Jefferson Park Road
Warwick, RI 02888
www.RICBF.org
Phone: 401-467-6813
Fax: 401-467-6816

New York Office
270 Motor Parkway
Hauppauge, NY 11788-5150
www.nrccf.org
Phone: 631-952-9700 Option 5
Fax: 631-952-9813

NORTH ATLANTIC STATES CARPENTERS ANNUITY FUND

APPLICATION TO BE COMPLETED BY BENEFICIARY

Name of Member

Social Security No.

Date of Birth

I hereby make application for **DEATH BENEFITS** payable from the North Atlantic States Carpenters Southern New England Carpenters Annuity Plan as a result of the death of the above Member. I understand that when this application is approved, it will be the only benefit payable from the Plan.

The Member named above died on _____
(Date of Death)

() I request to receive my annuity death benefit in the form of a lump sum (subject to 20% federal tax withholding).

() I request to rollover my annuity death benefit (Please complete rollover form on the back)

() I wish to receive my annuity death benefit in the form of monthly installments in the amount of
\$ _____

By signing this application, I agree that all statements made in connection with the application are true and the Trustees shall have the right to recover any overpayment of benefits.

() Death Certificate Enclosed

Name of Beneficiary, Executor, Administrator, Next of Kin
(Please print)

Signature

Address

Phone Number

Date of Birth

Date

Social Security Number

NORTH ATLANTIC STATES CARPENTERS ANNUITY FUND-DIRECT ROLLOVER FORM

NOTE: You should read the Notice called "Your Rollover Options" before you complete this Form. Also consult a tax advisor.

Your Name _____

Address _____

Social Security No. _____

(Check One)

_____ I direct the Fund to rollover 100% of my distribution to an IRA or another qualified plan (if it accepts rollovers).

_____ I direct the Fund to rollover \$ _____ directly to an IRA or another qualified plan (if it accepts rollovers). I direct the Fund to pay the balance of my distribution to me, reduced by income tax withholding (as required), in the form chosen on my Application for Benefits.

You must complete this information

Rollover is to a (check on) _____ IRA _____
Qualified Plan

Name of IRA Trustee or
Name of Qualified Plan _____

Mailing Address _____

Account Number _____

Your Contact & Phone Number _____

I certify that the information above relates to an Individual Retirement Account, an Individual Retirement Annuity or an IRS-qualified plan that accepts rollovers. I agree that payment as direct above releases the Fund and its Trustees from any obligation or liability regarding benefit payments due to me.

Your Signature

Date