SASMI TRUST FUND
8403 ARLINGTON BLVD., SUITE 310
FAIRFAX, VA 22031

RETIREE HEALTH PREMIUM BENEFIT APPLICATION FOR REIMBURSEMENT TO PARTICIPANT

PERSONAL DATA: (Please Print All Answers)

Name: _____
Last First Middle

Address: _____
Street Address

_____
City State Zip Code

IA No.: _____

Home Local Union No.: _____

Social Security No.: _____

Date of Birth: _____

Initiation Date: _____

Last Month Worked: _____ Retirement Date: _____
Month / Year

Please attach a copy of your Pension approval from your Local Pension Fund and/or the National Pension Fund.

In the event of a participant's death, retiree health benefits may be made to a participant's spouse. Please provide:

Name of Spouse: _____ Spouse's Social Security No: _____

Spouse's Date of Birth: _____

If applicable, indicate all dates, after your initiation, when you were not a member of the Sheet Metal Workers' International Association (Withdrew, Suspended, etc.).

Retiree Health Insurance Provider (please check all that apply):

_____ Private Insurance Carrier
Name of Carrier: _____
Address of Carrier: _____
Attach a copy of your proof of payment.

____ SMWIA Local Union _____ Welfare Fund
Name of Local Union Welfare Fund: _____
Address of Local Union Welfare Fund: _____
Telephone Number of Welfare Fund: _____
Attach a copy of your proof of payment.

Does premium include coverage for your spouse? _____ YES _____ NO

Current Monthly Premium Amount: $ _____ MARRIED $ _____ SINGLE

APPLICANT'S AUTHORIZATION:
The information I have set forth above is true and correct to the best of my knowledge and belief. I understand that a false statement or the withholding of pertinent information may disqualify me from benefits. I hereby authorize the SASMI Fund Office to obtain, when necessary, Social Security, Unemployment, Health and Welfare and other records for the sole purpose of processing SASMI Benefits. SASMI will not issue Retiree Health Benefits for more than three (3) months prior to the applicable quarter or six (6) months prior to the month in which the proof of payment is received in the SASMI office. Benefits will be issued on a quarterly basis and if any of the above information changes (including the premium amount), I agree to notify the SASMI office in writing within fifteen (15) days. I am enclosing the required proof of payment.

Date: _____ Applicant's Signature: _____

LOCAL UNION DATA: (TO BE COMPLETED BY LOCAL UNION OFFICIAL ONLY)

Has the applicant been employed with any non-union sheet metal contractor since the date of initiation? **DO NOT** include any work performed under the Youth-to-Youth program or authorized by the Local Union (salted organizer).

_____ YES _____ NO

I hereby certify that I am authorized to make the above statements on behalf of the Local Union. I also certify all statements above are true and correct to the best of my knowledge and belief, and according to the records of the Local Union.

Date: _____ **By:** _____
(Signature) **(Title)** **(Local Union #)**

SASMI TRUST FUND
8403 ARLINGTON BLVD., SUITE 310
FAIRFAX, VA 22031

RETIREE HEALTH PREMIUM BENEFIT APPLICATION FOR DIRECT PAYMENT TO LOCAL HEALTH FUND

PERSONAL DATA: (Please Print All Answers)

IA No.: _____

Name: _____
Last First Middle

Home Local Union No.: _____

Social Security No.: _____

Address: _____
Street Address

Date of Birth: _____

_____
City State Zip Code

Initiation Date: _____

Last Month Worked: _____ Retirement Date: _____
Month / Year

Please attach a copy of your Pension approval from your Local Pension Fund and/or the National Pension Fund.

In the event of a participant's death, retiree health benefits may be made to, or on behalf of, a participant's spouse. Please provide:

Name of Spouse: _____ Spouse's Social Security No: _____

Spouse's Date of Birth: _____

If applicable, indicate all dates, after your initiation, when you were not a member of the Sheet Metal Workers' International Association (Withdrew, Suspended, etc.).

Retiree Health Insurance Provider:

____ SMWIA Local Union _____ Welfare Fund

Name of Local Union Welfare Fund: _____
Address of Local Union Welfare Fund: _____
Telephone Number of Welfare Fund: _____

Does premium include coverage for your spouse? _____ YES _____ NO

Current Monthly Premium Amount: $ _____ MARRIED $ _____ SINGLE

APPLICANT'S AUTHORIZATION:
The information I have set forth above is true and correct to the best of my knowledge and belief. I understand that a false statement or the withholding of pertinent information may disqualify me from benefits. I hereby authorize the SASMI Fund Office to obtain, when necessary, Social Security, Unemployment, Health and Welfare and other records for the sole purpose of processing SASMI Benefits. I authorize the SASMI Fund to issue Retiree Health Premium Benefits on my behalf, or in the event of my death, on behalf of my spouse, to my Local Union Health Fund effective (month/year) _____. SASMI will not issue Retiree Health Benefits for more than six (6) months prior to the month in which the initial application is received in the SASMI office. Benefits will be issued on a quarterly basis and if any of the above information changes (including the premium amount), I agree to notify the SASMI office in writing within fifteen (15) days.

Date: _____ Applicant's Signature: _____

LOCAL UNION DATA: (TO BE COMPLETED BY LOCAL UNION OFFICIAL ONLY)

Has the applicant been employed with any non-union sheet metal contractor since the date of initiation? **DO NOT** include any work performed under the Youth-to-Youth program or authorized by the Local Union (salted organizer).

_____ YES _____ NO

I hereby certify that I am authorized to make the above statements on behalf of the Local Union. I also certify all statements above are true and correct to the best of my knowledge and belief, and according to the records of the Local Union.

Date: _____ **By:** _____
(Signature) (Title) (Local Union #)