# DEFERRED SALARY PLAN

## JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, N.Y. 11365
PHONE 1-718-969-4040

## APPLICATION FOR BENEFITS

***PLEASE PRINT***

NAME _____ _____
First Last

ADDRESS _____ SOC. SEC.# _____
Number and Street

_____ LOCAL UNION # _____
Town or City

_____ DIV. _____ UNION CARD # _____
State Zip Code PHONE # _____

***Note: You must first submit your request for reimbursement for all of the benefits indicated below to all other applicable benefit plans in which you have a balance.***

**Please answer below:**

1. Are you (check one) ☐ unemployed ☐ employed ☐ retired or left industry _____
Date

2. If employed, indicate employer's name: _____

3. I am applying for [check applicable box(es)]:

- ☐ Supplementary Unemployment Benefits
- ☐ Supplementary Workers' Compensation Benefits
- ☐ Supplementary Disability Benefits
- ☐ Supplementary Economic Assistance Benefits (Medical/Dental/Drugs)
- ☐ Supplementary Financial Assistance Benefits (Delinquent Mortgage/Rent) - Indicate month(s): _____
- ☐ Supplementary Vacation and Holiday Benefits - Indicate vacation dates: _____
- ☐ College Tuition Reimbursement Benefit: _____
Semester Child's Name
- ☐ Non-College Private School Tuition Reimbursement: _____
School Year Child's Name
- ☐ Cobra Premium Reimbursement: Month & Year: _____
- ☐ Jury Duty Benefit
- ☐ Funeral Leave Benefit - Indicate relationship of deceased to participant: _____
- ☐ Adoption Expenses
- ☐ Child Care Reimbursement

***Do not send in duplicate bills or bills previously submitted and paid through any other employee benefit plan.***

***I understand that all distributions for these benefits may be made only from the employer contribution portion of my Deferred Salary Plan account and are subject to the applicable taxes under IRS regulation as indicated on the back of this form.***

Date: _____ Signature: _____

***For Office Use Only***

| Code | Amount | Date | TB Amount | TB Date |
|---|---|---|---|---|
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***READ INSTRUCTIONS ON REVERSE SIDE***

# PAYMENT FROM THE DEFERRED SALARY PLAN

You should refer to your summary plan description booklet as to your eligibility to receive distribution from the Plan. Listed below is the required documentation that must be attached to this application in order for payment to be made to you. **The Plan reimburses benefits for up to one year with the exception of Economic Assistance which reimburses up to two years after the event or date the service is rendered.**

1. **Supplementary Unemployment, Disability or Workers' Compensation Benefits**
   In order to be eligible, you must be receiving Unemployment, Disability or Workers' Compensation Benefits. The applicant must furnish a photocopy of the Unemployment, Disability or Workers' Compensation check stub to the Plan. You must notify the Plan when you return to work.

2. **Supplementary Economic Assistance Benefits**
   In order to receive payment for unreimbursed hospitalization, medical, surgical, prescription drug, or dental expenses, the applicant must first submit bills to the Hospitalization Plan or Dental Plan. Submit the denial or Explanation of Benefits along with the form "A" or form "B" portion of this application. The Plan will also allow for reimbursement of COBRA premiums, Medicare Part "B" premiums, long term care premiums paid to an insurance company, and certain over the counter drugs, subject to Internal Revenue Code limits. Effective January 1, 2011, most over the counter drug reimbursement claims must be submitted with an original valid prescription. Claims submitted for nursing homes or assisted living must be accompanied by a letter of medical nesessity from a physician.

   In order to obtain reimbursement for a COBRA premium payment, the applicant is obligated to include a copy of the canceled check for the participant, a divorced spouse or dependent child.

   In order to obtain reimbursement for a Medicare Part "B" premium payment, the applicant must submit Form SSA-1099 on an annual basis.

   In order to obtain reimbursement for Long Term Care premiums paid to an insurance company, you must submit a copy of the premium statement along with a copy of both sides of the canceled check.

   Only those contributions made more than two years prior to the distribution date are available for COBRA, Medicare or Long Term Care premiums, unless the applicant has been a participant in this Plan for at least five years.

3. **Supplementary Financial Assistance Benefits**
   The applicant must submit an original delinquent mortgage payment coupon, rent bill or notarized Landlord Form along with proof of current unemployment. Additional information may be requested. This benefit is subject to a remaining account balance of $2,000.00.

4. **Supplementary Vacation and Holiday Benefits**
   The applicant will have to provide a letter from the employer indicating the vacation dates, unless already on file with this office, or a letter from the participant when requesting payment for a holiday. Only those contributions made more than two years prior to the distribution date are available, unless the applicant has been a participant in the Plan for at least five years.

5. **College Tuition and Non-College Private School Tuition Reimbursement**
   The applicant must attach an original itemized paid bill on school letterhead, including the student's name, semester/school year and dollar amount paid. Tuition bill must be signed by a financial representative of the school and must bear the school's seal or stamp. Reimbursement may be requested on an annual or semi-annual basis. This benefit is subject to a remaining account balance of $2,000.00.

6. **Jury Duty Benefit**
   Members who are *not* eligible for the regular Jury Duty benefit from the Educational and Cultural Trust Fund must attach the original receipt from the court as proof of serving jury duty.

7. **Funeral Leave Benefit**
   The applicant must attach a certified death certificate. This benefit is limited to immediate family: spouse, parent, spouse's parent, child (natural, adopted, or dependent), grandchild, brother and sister.

8. **Adoption Expenses**
   Qualified adoption expenses, including court costs, attorney and other related fees, may be reimbursed if related to the adoption of a child under the age of 18. Original paid bills, as well as a copy of the final adoption document, are required. The maximum withdrawal is $10,000.00, subject to a remaining account balance of $2,000.00.

9. **Child Care Reimbursement**
   Bills for Child Care Services must be from a certified day care center that provides supervision and care of a child through age 12. An original letter must be submitted from the provider that includes the name of the child, the amount that was paid by the participant, a description of the services provided and the time period. The letter, on the provider's letterhead, must be signed by an official or officer of the institution. Child Care reimbursement is allowed up to a net of $10,000 per calendar year, per child. The particpant must maintain a minimum $10,000 balance in their employer contribution account.

***Important:***

- Distributions from the Plan are subject to 20% federal income tax withholding, as required by IRS regulations.
- Withdrawals by a participant who is still working in the electrical industry and is younger than 59 ½ or by a participant who withdraws from the industry prior to age 55 are subject to the IRS additional tax of 10%.
- There is **no** 10% IRS Early Withdrawal Additional Tax when a payment is made to an active participant who is 59 ½ or older or to a participant who retires under the provisions of the Pension Trust Fund of the Electrical Industry, or if someone is "disabled" within the meaning of the Internal Revenue Code.

FORM "A" **MEDICAL AND DENTAL RECORD** FORM "A"

DEFERRED SALARY PLAN OF THE ELECTRICAL INDUSTRY
**158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, NY 11365**

**INSTRUCTIONS:** *Please read carefully:*
List your MEDICAL AND/OR DENTAL BILLS ONLY ON THIS FORM
List bills in date order. Bills will not be accepted unless properly listed on this form. Form will not be accepted unless accompanied by original bills or an Explanation of Benefits voucher. Do not send in duplicate bills or bills previously submitted and paid through any other employee benefit plan. Return application, this form and bills, or an Explanation of Benefits voucher in the enclosed self-addressed envelope. SIGN THIS FORM at the bottom.

| Date of Service | Provider's Name | Patient's Name | Relationship of Patient (Self, Spouse, Child) | Amount to be Reimbursed |
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**Total Amount to be Reimbursed $ _____**

**NOTICE**

Any intentional statement of incomplete and/or incorrect information may result in disciplinary action including the institution of a civil and/or criminal proceeding. I have read the foregoing Notice and I certify to the completeness and accuracy of this application.

_____
Print Participant's Name

_____ _____ _____
Participant's Signature Social Security Number Date

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FORM "B" **PRESCRIPTION AND/OR OVER-THE-COUNTER DRUG RECORD**

DEFERRED SALARY PLAN OF THE ELECTRICAL INDUSTRY
**158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, NY 11365**

**INSTRUCTIONS:** *Please read carefully:*

List your PRESCRIPTION AND/OR OVER-THE-COUNTER DRUG RECEIPTS ON THIS FORM. *For a list of covered and non-covered over-the-counter drugs, please see the back of this form.*
List bills in date order. Bills will not be accepted unless properly listed on this form. This form will not be accepted unless accompanied by original itemized receipts or an Explanation of Benefits voucher. Do not send in duplicate bills or bills previously submitted and paid through any other employee benefit plan. Return application, this form and receipts, or an Explanation of Benefits voucher in the enclosed self-addressed envelope. SIGN THIS FORM at the bottom.

| Date of Service | Name of Drug or Product | Patient's Name | Relationship of Patient (Self, Spouse, Child) | Amount to be Reimbursed |
|---|---|---|---|---|
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**Total Amount to be Reimbursed $ _____**

***NOTICE***

Any intentional statement of incomplete and/or incorrect information may result in disciplinary action including the institution of a civil and/or criminal proceeding. I have read the foregoing Notice and I certify to the completeness and accuracy of this application

_____
Print Participant's Name

_____ _____ _____
Participant's Signature Social Security Number Date

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***- OVER-***

**Covered Over-the-Counter Medications include:**

| | |
|---|---|
| Allergy Medicine | Analgesics |
| Antihistamines | Antacids |
| Anti-Diarrhea Medication | Aspirin |
| Calcium Supplements (only if recommended by a doctor for a specific condition) | Cold Medicine |
| Contact Lens Solution | Cough Drops |
| First Aid Cream (Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatments) | Hemorrhoidal Medications |
| Lactose Intolerance Pills | Laxatives |
| Menstrual Cycle Medications | Motion Sickness Pills |
| Muscle/Joint Pain Relief (i.e. Ben-Gay, Tiger Balm) | Nasal Sinus Spray |
| Nicotine Gum/Patches | Pain Reliever |
| Pedialyte | Reading Glasses |
| Rubbing Alcohol | Sinus Medications |
| Smoking Cessation Products | Throat Lozenges |
| Visine | Wound Care Products |

**Over-the-Counter Medications not covered include but are not limited to:**

| | |
|---|---|
| Chapstick | Cosmetics |
| Cotton balls/swabs | Face Cream |
| Hair Loss Medication/Rogaine | Medicated Shampoos/Soaps |
| Moisturizers | One-a-Day Vitamins/Vitamins for General Health |
| Suntan Lotion | Toiletries |
| Toothbrushes | Toothpaste |
| Teeth Whitening Products | Topical Creams |
| Nutritional Supplements | Nasal Sprays (for snoring) |
| Sleeping Aids | Pre-Natal Vitamins |
| Pregnancy Tests | |