

INQUIRY REGARDING PENSION CREDITS

TO: UFCW — Employers Benefit Funds
 Drawer 9000, Walnut Creek, California 94598-0900
 Phone # (925) 746-7530 (800) 794-5678

Please check:
 Food/Meat Industry Employment
 Drug Store Employment
 Specialty Stores Employment

EMPLOYEE to complete / Print or Type

NAME	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	UFCW Union #
STREET ADDRESS	SOC. SEC. NUMBER	DATE OF BIRTH
CITY STATE ZIP	DATE FIRST EMPLOYED IN INDUSTRY	
TELEPHONE (DAYS)	DATE LAST EMPLOYED IF NOT CURRENT	
ANY OTHER SURNAME – e.g., maiden	I AM PLANNING TO RETIRE SOON <input type="checkbox"/> Yes <input type="checkbox"/> No	
ARE YOU WORKING AT PRESENT IN CALIFORNIA UNDER A UFCW CONTRACT? IF NO, PLEASE ADVISE YOUR CURRENT WORK STATUS <input type="checkbox"/> Yes <input type="checkbox"/> No		

Complete your employment history below beginning with the store or company where you are now employed and list all jobs back to the first one, showing the type of work performed.

	NAME OF STORE/COMPANY	CITY	CLASSIFICATION (Clerk, Meatcutter, Pharmacist, Manager, etc.)	DATES OF EMPLOYMENT			
				From		To	
				Month	Year	Month	Year
1	Present Employer						Present
2							
3							
4							
5							
6							
7							
8							

Please complete the section below for all periods of your work history during which you were not in a union position in the industry.

REASONS FOR BREAK IN EMPLOYMENT	DATES OF BREAKS IN EMPLOYMENT			
	From		To	
	Month	Year	Month	Year
Military Service (ATTACH DD-214's)				
Illness or injury (PROVIDE DOCTOR'S NAME AND COMPLETE MAILING ADDRESS ON BACK OF FORM)				
Exempt Employment (EMPLOYER/POSITION/LOCATION)				
UFCW employment outside Northern California (EMPLOYER AND LOCATION)				
Worked in other industry or trade (EMPLOYER AND TYPE OF WORK)				
Self-Employment (TYPE OF STORE/INDUSTRY/LOCATION)				
Other Causes (STATE BRIEFLY AND GIVE DATES):				

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning my history. A copy or photocopy of this authorization shall be as valid as the original.

Signature _____

Date _____

THIS IS NOT AN APPLICATION FOR RETIREMENT BENEFITS.
If you wish to apply for Pension Benefits, contact your Union Local or the Fund Office.

AUTHORIZATION TO OBTAIN EARNINGS DATA FROM THE SOCIAL SECURITY ADMINISTRATION

TO BE FILLED IN BY FUND OFFICE ONLY

JOB #: _____

FUND: _____

NAME _____

SS# _____

DATE OF BIRTH _____

Social Security Administration
300 N. Green Street
Baltimore, Maryland 21201

Please furnish the above-named Fund, Drawer 9000, Walnut Creek, California 94598-0900, an itemized statement of all quarterly and annual amounts of wages reported to my record for the periods specified by that organization, and the identification numbers, names and addresses of the reporting employers.

Date Signed

Signature of Social Security Number Holder

TO BE FILLED IN BY PENSION FUND OFFICIAL ONLY

SOCIAL SECURITY ADMINISTRATION:

Please furnish the above information for the period _____

This information is to be used only to determine initial eligibility for benefits.

Countersignature of Pension Fund Official
