SOUND VARIABLE ANNUITY PENSION TRUST

11724 NE 195th Street, Suite 300, Bothell, Washington 98011-3145
(206) 282-4500 -or- (800) 225-7620, option 2 then option 3

APPLICATION FOR DISABILITY RETIREMENT BENEFITS

1. Please read each question carefully.
2. Print or type all information.
3. Be sure to answer all applicable questions to avoid delay in processing your application.
4. Attach additional sheets if you need more space to answer any questions.
5. BE SURE TO SIGN AND DATE THIS APPLICATION.
6. The application must be received at the Trust Office by the end of the month in which retirement benefits are to be effective.
7. Mail the completed application and proof of age to the above address.
8. You should receive an acknowledgment letter within 14 business days from the date you mail your application. If you do not receive your acknowledgment letter, please call the Trust Office at (800)225-7620, option 2 then option 3.

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1. Name _____
   Last First Middle
2. Previous Name _____ Date Changed _____
3. Social Security # _____ Phone # _____
4. Mailing Address _____
   Street Number City State Zip Code
5. Email _____ Local Union # _____
6. Gender: ☐Male ☐Female Birthdate _____
7. Marital Status: ☐Married ☐Legally Separated ☐Divorced ☐Widowed ☐Single

   Have you ever been divorced? ☐Yes ☐No

   If yes, is there a DOMESTIC RELATIONS ORDER/PROPERTY SETTLEMENT in effect awarding a portion of your possible pension benefits to your former spouse? ☐Yes ☐No

   If yes, please provide a copy of the ORDER.
8. Current Spouse's Name _____
   Last First Middle
9. Spouse's Social Security # _____ Spouse's Birthdate _____
10. Spouse's Gender: ☐Male ☐Female
11. In accordance with the terms of the Sound Variable Annuity Pension Trust, I hereby apply for Disability Retirement Benefits.* Date of Disability: _____.

    *If you apply for Disability Benefits and do not qualify, you may convert this application to an Early Retirement Application provided you are eligible for Early Retirement Benefits.

10. Have you ever worked as a sole proprietor, partner or corporate owner of a participating employer?
    ☐YES ☐NO If YES, please explain in **Employment History Section** on Page 4.
11. The last day I worked was on or will be on _____ _____ _____
    Month Day Year
12. I will be eligible for payment of additional accrued vacation or work hours earned prior to my last date of employment.
    ☐YES ☐NO If YES:

    How much time will you be eligible for? _____ When will it be paid? _____
13. I hereby request that my retirement be effective on the first day of _____ _____
    Month Year

All sections must be completed.

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PLEASE READ THIS SECTION CAREFULLY

I understand and agree that it is my responsibility to submit any and all information needed to establish my eligibility for retirement under this Trust and that this application can be canceled by written request submitted to the Trust Office prior to its Effective Date. I certify that the information on this form is true and accurate to the best of my knowledge.

I also authorize the release of my medical records to the Administrative Agent for the purpose of determining my benefits payable under the provisions of this Plan or any other Plan. I am personally responsible for any expenses incurred in providing this information. I also authorize the release of this information to the Sound Health and Wellness Trust (if applicable).

I understand the conditions of my retirement are governed by the Plan rules and regulations.

I understand that in the case of an overpayment of my pension benefits, the Trustees are entitled to recover any amounts overpaid to me.

If no information appears under the Spouse's Section above, I certify that I am not married.

_____ _____

Applicant's Signature Date

AGE AND MARRIAGE VERIFICATION

A copy of your and your spouse's birth certificate, and proof of your marriage, is required to process your request.

If you are unable to obtain a copy of either of your birth certificates, you must submit **TWO** of the following documents for each person who does not have a birth certificate.

The following documents, if submitted, **MUST** show your birthdate:

Driver's License with Photograph
State Identification Card with Photograph
Passport
Marriage Records Showing Birthdate
Citizenship or Naturalization Papers
Baptismal Certificate (regardless of when it was recorded)
Records or information obtained from the U.S. Census Department
Life Insurance policies taken out at least 10 years prior to your date of retirement
Social Security Information including birthdate
U.S. Armed Forces Records
School records established prior to 21st birthday and showing birthdate
Affidavit of Birth (provided by Trust Office, if needed)

Important: If the name on either your or your spouse's birth certificate is different from your present names, you must also submit a copy of the court order, marriage certificate, affidavit or other document to show the name change(s).

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REQUEST FOR TEMPORARY EARLY RETIREMENT BENEFITS

The Sound Variable Annuity Pension Trust provides for Participants who are over age 55 and applying for Disability Retirement Benefits to elect to begin receiving temporary Early Retirement Benefits while a formal determination is being made regarding their disability.

If you choose to begin receiving Temporary Early Retirement Benefits, and your disability is subsequently established to the satisfaction of the Trustees within 36 months of the Early Retirement Benefit Effective Date, Disability Retirement Benefits would be paid retroactive to the **later** of (a) the Effective Date of the Early Retirement Benefit or (b) the date the applicant first met the requirements for a Disability Retirement Benefit.

> *For example: If you work until January 14 and become disabled on January 15, and then apply for benefits in May, your **disability** retirement date would be February 1. However, if you elect to take Temporary Early Retirement Benefits, your **early** retirement date would be May 1, and once your disability was substantiated, your **disability** benefits would be paid effective May 1.*

If you elect to receive Temporary Early Retirement Benefits and are unable to substantiate your disability within 36 months of the Early Retirement Benefit Effective Date, you will not be allowed to convert to a Normal or Disability Retirement Benefit at a later date. Further, you will remain on Early Retirement and be subject to the return to work provisions outlined in Section 9.07 of the Plan Document.

If you elect not to receive Temporary Early Retirement Benefits, your effective date will be determined in accordance with Section 3.11 of the Plan and your benefits will be paid retroactive to that date once your disability is established and the Trustees approve your application.

Please indicate below if you would like to take advantage of Temporary Early Retirement.

- ☐ I do want to receive Temporary Early Retirement Benefits while I attempt to substantiate my disability.
- ☐ I do not want to receive Temporary Early Retirement Benefits. I prefer to wait until my disability is established before I begin receiving benefits.
- ☐ I am not yet age 55 or older, therefore I am not eligible for Temporary Early Retirement Benefits.

By signing below I certify that I have read and understand this notice and wish to pursue my benefits as indicated above.

_____ _____

Signature of Applicant Date

_____

Social Security Number

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UNION MEMBERSHIP HISTORY

Please list all of the Local Unions of which you have been a member and the periods of your membership. Begin with your current or most recent membership and work backwards.

Local Number	Trust Name City State	Initiation Mo. / Yr.	Withdrawal Mo. / Yr.

Please make sure all sections of this application are completed.

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EMPLOYMENT HISTORY

Please list all your employers and periods of employment. Begin with your current or most recent employer and work backward to your first employment in the Industry. Be sure to include any time spent in the military, as an owner, or out of the Industry. **You do not need to list employment prior to 1945.**

EMPLOYER	EMPLOYER'S ADDRESS	Hours Worked Per Week	Employment FROM Mo. / Yr.	Employment TO Mo. / Yr.	JOB CLASSIFICATION Example: Cashier, Baker, Clerk, Pharmacist, Manager, Owner, Partner, Corporate Officer, etc.

Please make sure all sections of this application form are completed.

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MEDICAL QUESTIONNAIRE

Instructions: Please type or print legibly in ink. Answer each question as it applies to you. List any other information you consider relevant to your condition.

1. Full Name: _____
   Last First Middle
2. Social Security Number: _____
3. Describe your disability: _____
   _____
   _____
4. What was the cause of your disability? _____
   _____
   _____
5. What date did you become disabled? _____
6. What was your last date of employment? _____
7. Did your disabling condition cause you to cease your employment? Yes ☐ No ☐
   If yes, briefly describe these circumstances: _____
   _____
   _____
8. Are you able to perform ***any*** duties or occupation covered by the last labor agreement under which you worked? Yes ☐ No ☐
9. Have you inquired with your Union or your Employer about other employment? Yes ☐ No ☐
10. List all jobs or duties which you performed in this Industry: _____
    _____
11. Have you received ***any*** training for any other job or duties in this Industry? Yes ☐ No ☐
    If yes, describe the training: _____
    _____
12. Describe the last job you performed for your Employer: _____
    _____
13. Why did you leave employment with your Employer? _____
    _____
14. List all of your formal education by grade levels:

School	Grade Level	Years

Please make sure all sections of this application form are completed.

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MEDICAL QUESTIONNAIRE, continued

15. List all technical or vocational training which you have received (including Armed Force Training):

School	Grade Level	Years

16. List and describe all other job-type functions or activities acquired through self-instruction, hobbies or the like: _____

17. List all other crafts, trades and professions in which you have been employed and the duties which you performed in each:

Job Description	Duties	Years

18. Are you presently capable of performing any of the jobs described above? Yes ☐ No ☐
If no, state why: _____

19. Have you applied for Federal Social Security Disability Benefits? Yes ☐ No ☐
If yes, a) Date of application _____
b) Date of award or denial _____

20. **ATTACH COPIES OF ANY OTHER DISABILITY AWARDS OR DENIALS FROM STATE OR FEDERAL AGENCIES.**

21. Other Information: _____

Please make sure all sections of this application form are completed.

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PLEASE PROVIDE COMPLETE NAME AND ADDRESS OF YOUR PHYSICIAN(S)

List **all** doctors or medical providers who are or have treated your disabling condition(s) and the date of your last visit.

Please provide copies of any reports or exams which document your disabling condition(s).

Example:

Physician's Name **and** Specialty	Address **and** Phone Number	Date Last Visited
Dr. John Smith, Orthopedic Surgeon	1234 ABC Street Anytown, USA 98109 206-987-6543	1/15/2007

Primary Care Physician	Address **and** Phone Number	Date Last Visited

Other Physicians

Name **and** Specialty	Address **and** Phone Number	Date Last Visited

The Participant is personally responsible for any expenses incurred in providing this information.

Please make sure all sections of this application form are completed.