PENSION –VACATION-ANNUITY
PHONE # 631-739-0020

PLUMBERS LOCAL UNION NO. 200

FRINGE BENEFIT FUNDS

2121 5TH AVENUE, RONKONKOMA, N.Y. 11779
FAX # 631-739-0022

WELFARE
PHONE # 631-739-0021

ADDITIONAL SECURITY BENEFITS FUND
PLUMBERS LOCAL #200
APPLICATION FOR EDUCATIONAL BENEFIT

NAME OF MEMBER: ____

SOCIAL SECURITY NUMBER: ______-_______-____________

ADDRESS: ____

(Number and Street)

____

(City) (State) (Zip Code)

NAME OF CLAIMANT: ____

SOCIAL SECURITY NUMBER: ______-_______-____________

The undersigned hereby makes application for an Educational Benefit in the amount of $_______________. (Please attach all bills and receipts to certify this application)

The undersigned hereby acknowledges that he/she is fully aware that Educational Benefits for a dependent (not the member) are subject to deductions for Federal and State income taxes, FICA (both employee's and employer's portion of Social Security contributions), FUTA (employer's portion of Federal Unemployment Taxes), and consents to the deduction of said taxes by the Trustee's which will be forwarded to the appropriate agency.

Educational Benefits for a **MEMBER** who is seeking re-imbursement for trade related expenses are **NOT** taxable and **NO** taxes will be withheld by the Trustees.

The undersigned also agrees to sign such statements and affidavits as the Trustees may require with respect to this application.

SIGNATURE OF APPLICANT: ____

DATE: ____/____/________ WITNESS: ______________________________

Robert Ruggiero, Co-Chairman
John Botto, Trustee
Dominick D'Elia, Trustee
Louis Maccarone, Trustee

Danny Grodotzke, Co-Chairman
Richard P. Brooks, Trustee
Mario Mattera, Trustee
Arthur M. Gipson, Trustee

Frank J. Pellegrino, Fund Administrator

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ADDITIONAL SECURITY BENEFITS FUND
PLUMBERS LOCAL UNION #200
APPLICATION FOR SUPPLEMENTAL VACATION BENEFIT

The maximum allowable benefit in any one year is $2,500.00

NAME OF CLAIMANT:____

ADDRESS:____
(Number and Street) (City) (State) (Zip Code)

SOCIAL SECURITY NUMBER: ______-_____-_________

The undersigned hereby makes application for the Supplemental Vacation Benefit in the amount of $ ______________. (Amount subject to the extent of available accumulated service credits held in the name of the participant).

The undersigned herby acknowledges that he/she is fully aware that Supplemental Vacation Benefits are subject to deductions for Federal and State income taxes, FICA (both employee's and employer's portion of Social Security contributions), FUTA (employer's portion of Federal Unemployment Taxes) and consents to the deduction of said taxes by the Trustee's which will be forwarded to the appropriate agency. The undersigned also agrees to sign such statements and affidavits as the Trustees may require with respect to this application.

SIGNATURE OF APPLICANT: ____

DATE: ____/____/________ WITNESS: ______________________________

Robert Ruggiero, Co-Chairman
John Botto, Trustee
Dominick D'Elia, Trustee
Louis Maccarone, Trustee

Danny Grodotzke, Co-Chairman
Richard P. Brooks, Trustee
Mario Mattera, Trustee
Arthur M. Gipson, Trustee

Frank J. Pellegrino, Fund Administrator

PENSION –VACATION-ANNUITY
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PLUMBERS LOCAL UNION NO. 200

FRINGE BENEFIT FUNDS

2121 5TH AVENUE, RONKONKOMA, N.Y. 11779
FAX # 631-739-0022

WELFARE
PHONE # 631-739-0021

Dear Member:

Enclosed is the form required by the Board of Trustees for withdrawals from the Additional Security Benefits Funds. Be sure to complete the entire form explaining the nature of your claim. Be sure the form is signed by you (the member) and witnessed by a second party.
The balance in your account is $____________. **All claims submitted must be for services performed within one year of the date of the next Board meeting.** The Board of Trustees meets on the second Tuesday of each month and the next scheduled meeting will be held on ___/___/______. Forms must be received by the Fund Office at least one week prior to the meeting. You may claim benefits for the following:

DENTAL

Dental bill not covered by insurance. All bills must be itemized showing the name of the patient and a description of the procedures performed. Bills must be for services rendered. You may claim benefits for procedures not covered under the plan such as elective or cosmetic procedures.

MEDICAL

Medical bills not covered by insurance. All medical bills must be submitted to the plan and you must attach an EOB showing the uncovered amount. You may claim benefits for any amount not covered under the plan. You may also claim benefits not covered under the plan, such as elective of cosmetic procedures. You may claim benefits for unpaid prescription drugs only. You may claim benefits for COBRA payments however this claim is taxable.

EDUCATION

You may claim benefits for **COLLEGE** expenses only, e.g. Tuition, room and textbooks. Application for EDUCATIONAL BENEFITS is on a separate form. Educational benefits are taxable unless the benefit if for a member advancing themselves in the Plumbing trade.

VACATION

Please request an application for SUPPLEMENTAL VACATION.

Sincerely

Frank J. Pellegrino
Fund Administrator

Robert Ruggiero, Co-Chairman
John Botto, Trustee
Dominick D'Elia, Trustee
Louis Maccarone, Trustee

Danny Grodotzke, Co-Chairman
Richard P. Brooks, Trustee
Mario Mattera, Trustee
Arthur M. Gipson, Trustee

Frank J. Pellegrino, Fund Administrator

PROOF OF CLAIM FOR ECONOMIC ASSISTANCE

THIS FORM IS TO BE COMPLETED WHEN A CLAIM FOR BENEFITS UNDER THE ADDITIONAL SECURITY BENEFITS PLAN COVERING DENTAL, MEDICAL OR PRESCRIPTION DRUG REIMBURSEMENT IS MADE. CLAIMANT MUST ATTACH ITEMIZED BILLS OR EOB'S WHEN CLAIMING BENEFITS. ONLY ONE FORM IS NEEDED FOR ALL CLAIMS.

NAME OF PARTICIPANT: ____

SOCIAL SECURITY NUMBER: ________-_______-______________

ADDRESS: ____
(Number and Street)

____
(City) (State) (Zip Code)

If Claim is for a dependent, please list the following:

NAMES: __________________________________ RELATIONSHIP: ____________________

NAMES: __________________________________ RELATIONSHIP: ____________________

NAMES: __________________________________ RELATIONSHIP: ____________________

NAMES: __________________________________ RELATIONSHIP: ____________________

PARTICIPANTS EMPLOYER: ____

NATURE OF CLAIM: ____

AMOUNT REQUESTED: $_______________________

I hereby authorize any hospital, physician, firm, company or other person who has attended or examined me or any of my dependents, or who has had related business dealings with me or a listed dependent to disclose any and all information regarding illness, injury, medical history, consultation, prescriptions, treatments or business dealings relative to this claim when requested by the Board of Trustee's and to provide copies of all records thereof affecting me or my dependents in connection with this claim. A copy of this authorization shall be considered as effective and valid as the original.

I swear that the foregoing statements are true and accurate to the best of my knowledge, knowing that the Board of Trustee's of the Additional Security Benefits Fund will rely thereon in its consideration of this claim.

SIGNATURE OF APPLICANT: ____

DATE: ____/____/________ WITNESS: ____