INQUIRY REGARDING PENSION CREDITS

TO: UFCW — Employers Benefit Funds
P.O. Box 8085 Walnut Creek, California 94596-8085
Phone # (800) 552-2400

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

EMPLOYEE to complete / Print or Type

NAME	SEX ☐ Male ☐ 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 ☐ Yes ☐ No	
ARE YOU WORKING AT PRESENT IN CALIFORNIA UNDER A UFCW CONTRACT? ☐ Yes ☐ No	IF NO, PLEASE ADVISE YOUR CURRENT WORK STATUS	

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 Month	From Year	To Month	To 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 Month	From Year	To Month	To 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.

FOR PERIODS OF DISABILITY PLEASE PROVIDE COMPLETE PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER BELOW

Period Disabled

_____ thru _____
mm/dd/yy mm/dd/yy

Physician's Name: _____

Address: _____

City/St/Zip: _____

Telephone Number: _____

Did you receive Worker's Compensation? ☐ Yes ☐ No

State Disability? ☐ Yes ☐ No

If you answered "Yes" to either question, please attach copies of benefit payments.
(If you do not have all copies, please contact State Disability for Form DIS0306 or your Workers' Compensation carrier to obtain a print-out of their payment records.)

Period Disabled

_____ thru _____
mm/dd/yy mm/dd/yy

Physician's Name: _____

Address: _____

City/St/Zip: _____

Telephone Number: _____

Did you receive Worker's Compensation? ☐ Yes ☐ No

State Disability? ☐ Yes ☐ No

If you answered "Yes" to either question, please attach copies of benefit payments.

Period Disabled

_____ thru _____
mm/dd/yy mm/dd/yy

Physician's Name: _____

Address: _____

City/St/Zip: _____

Telephone Number: _____

Did you receive Worker's Compensation? ☐ Yes ☐ No

State Disability? ☐ Yes ☐ No

If you answered "Yes" to either question, please attach copies of benefit payments.