



## Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor  
Springfield, New Jersey 07081  
(973) 671-6800

Pre-Cert and PPO  
(800) 677-3237

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### EMPLOYER TRUSTEES

JACK KOCSIS, JR., *CO-CHAIRMAN*  
BRENDAN MANNING  
DAVID MURAWSKI  
CHRIS VOLLERS

SHERRY VISO  
*ADMINISTRATOR*



### UNION TRUSTEES

GREGORY LALEVEE, *CO-CHAIRMAN*  
JOSEPH A. GRACE, JR.  
ALEX KOLBASOWSKI  
JOHN WOOD

Dear Participant:

In order to begin processing your request for a Disability Pension, please complete the enclosed forms and return along with copies of the following:

1. Social Security Disability Award Certificate.
2. A letter from your current doctor giving a detailed description of your disability.
3. Your Birth Certificate & Your Spouse's Birth Certificate.
4. Your Social Security Card & Your Spouse's Social Security Card.
5. Your Marriage Certificate (If you are/were divorced, you must submit a copy of any Qualified Domestic Relations Order or any other judgment, decree or order, including approval of a property settlement agreement).

In accordance with the Pension Plan, disability pension payments shall commence on the later of (1) the date on which the Participant is first entitled to payment of disability benefits from Social Security or (2) the date that is twenty-four months prior to the first day of the month following receipt of a complete written application. If you have not yet been awarded Social Security Disability, have reached age 55 and wish to apply for an early retirement pension with reduction, please submit a written letter of your intent. If you are subsequently awarded Social Security Disability, your pension benefit will be converted to a disability pension.

In addition, please contact your Local Union Hall concerning your Union Book Status after retirement.

New Hampton, NY  
(845) 674-9020

Springfield, NJ  
(973) 671-6900

Bordentown, NJ  
(856) 470-1480

Should you have any questions please contact the Pension Department at (973) 671-6800.

*MUE Local 825 Pension Department*

# OPERATING ENGINEERS LOCAL 825 PENSION FUND

## APPLICATION FOR DISABILITY PENSION



APPLICANT INFORMATION		
Name:		
Date of birth:	SSN:	Marital Status: S M W D (Please circle)
Current address:		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	E-Mail:
<b>I am applying for a disability pension. My retirement date is: (mm/dd/yyyy)</b>		
EMPLOYMENT INFORMATION		
Please list your Local 825 employers for the last six (6) months. If more space is required, then please list additional employers on a separate sheet. If you have not been employed during the last six (6) months, please indicate your last Local 825 employer:		
Employer:	End Work Date:	
DISABILITY INFORMATION		
My incapacity resulted from the following bodily injury or disease:		
I have been approved for disability benefits through the Social Security Administration: Yes No (please circle one)		Date of Award:
SPOUSE INFORMATION (IF MARRIED)		
Name:		
Date of birth:	SSN:	Date of marriage:
Current address (If different than applicant):		
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	E-Mail:
APPLICANT'S STATEMENT		
<p>This is my application for a pension based upon my disability. Total disability means a total and permanent inability to engage in employment as determined by the Social Security Administration and as evidenced by the granting of a Social Security Disability Award. Partial Disability means the inability to work as an Operating Engineer due to demonstrable injuries or disease as determined by a physician selected by the Trustees and where no Social Security Disability Award has been granted. A Participant shall not be considered totally or partially disabled if the injury or illness is caused by habitual drunkenness, illegal use of drugs, commission of a crime, an intentional act, or service in the armed forces* (*only applicable if credited service is less than twenty-five years).</p> <p>I represent to the Pension Fund that I am either totally or partially disabled as defined above and have attached to this application a report from my doctor confirming disability.</p>		
Signature of applicant:		Date:
Signature of spouse (if married):		Date:

**For Office Use Only**

GROSS PENSION \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NET PENSION \_\_\_\_\_

\_\_\_\_\_

AGE: Applicant \_\_\_\_\_ Spouse \_\_\_\_\_ CREDIT TOTAL \_\_\_\_\_ PENSION TYPE \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

Option chosen by applicant: 1.  2.  2A.  3.  3A.  4.  4A.  5.  6.

# **OPERATING ENGINEERS LOCAL 825 PENSION FUND**

## **EMPLOYMENT AFTER RETIREMENT**



### **Employment After Retirement**

The International Union of Operating Engineers Local 825 Pension Plan provides for the suspension of pension benefits for any month in which you engage in disqualifying employment as outlined below.

For purposes of benefits accrued prior to January 1, 2007:

You engage in disqualifying employment if employed forty (40) hours or more per month, whether or not under a collective bargaining agreement, performing work covered by any classification described in the Union's Collective Bargaining Agreement within the geographic jurisdiction of the Union.

For purposes of benefits accrued on or after January 1, 2007:

If you have not yet attained age sixty-two (62), you engage in disqualifying employment if employed for one (1) hour or more per month, whether or not under a collective bargaining agreement, performing work covered by any classification described in the Union's Collective Bargaining Agreement within any state of the United States or any province of Canada.

If you have attained age sixty-two (62), you engage in disqualifying employment if employed for forty (40) hours or more per month, whether or not under a collective bargaining agreement, performing work covered by any classification described in the Union's Collective Bargaining Agreement within the states of New Jersey or New York, or within any Standard Metropolitan Statistical Area, as defined from time to time by the United States Department of Labor, which is situated in whole or in part in New Jersey or New York.

You are required to notify the Plan in writing within 21 days after starting any work of any type that is or may be disqualifying and when you stop such employment. Written notice may be sent to Operating Engineers Local 825 Pension Fund, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081.

Any benefits paid for a month in which benefits should have been suspended shall be recoverable through deductions from future pension payments in accordance with Article 6.5 of the Pension Plan.

As mentioned above, you must notify the Plan when disqualifying employment has ended. Benefit payments shall resume no later than the first day of the third month after the last calendar month in which you are employed in disqualifying employment. Your initial benefit payment upon resumption shall include the payment scheduled to occur in the calendar month when payments resume and any amounts withheld during the period between the cessation of employment and resumption of

payments. Any overpayments resulting from payments made for any months for which you engaged in disqualifying employment shall be deducted from pension payments otherwise paid or payable upon resumption of pension payments. The deduction shall not exceed 25 percent of your total monthly benefit payment, except for the initial payment upon resumption of pension payments.

The amount of your pension benefit when resumed following suspension shall be recalculated to include additional pension benefit accruals during your period of reemployment. Any payment options in effect prior to the suspension of benefits shall remain in effect.

The Pension Plan provides a procedure for appealing any determination made by it regarding the suspension of benefit payments. A description of the Plan's appeal process is outlined in Article 11.3 of the Plan. The applicable Department of Labor regulation addressing the suspension of pension benefits may be found in 2530.203.3 of the Code of Federal Regulations.

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A retiree who engages in disqualifying employment will have his or her welfare benefits (including life insurance benefits) suspended. Such retiree will be permitted to purchase welfare benefits on a monthly basis until eligibility for welfare coverage has been established through sufficient employer contributions made on his or her behalf. Should such retiree not establish eligibility for welfare coverage either because of insufficient employer contributions received on his or her behalf or because of the retiree's failure to purchase benefits on a monthly basis, NO LIFE INSURANCE BENEFITS WILL BE PAID.

I have reviewed a copy of these rules regarding Employment After Retirement and fully understand the consequences of returning to work.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# OPERATING ENGINEERS LOCAL 825 WELFARE FUND

## IMPORTANT INFORMATION REGARDING RETIREE HEALTH COVERAGE

### (Medicare and Benefit Coordination)



Members who retire under the Pension Plan with at least 10.00 years of Credited Service and who satisfy eligibility criteria detailed in the Welfare Plan may purchase continued health coverage as a retiree for a period of time which is based upon years of Credited Service at retirement. Please refer to Eligibility of Retired Members in the Summary Plan Description (benefit booklet) for the Welfare Plan. It is important that you notify any health care plans under which you are covered that you are retiring and evaluate the impact your retirement may have on your continued eligibility under such plans. Also, if you are married and you and/or your spouse are covered under another health care plan based on your spouse's active employment, you may wish to evaluate what impact your spouse's retirement may have on your and/or your spouse's continued eligibility under such plan.

When you retire, you will be given the option to continue or decline to continue your health coverage. If you elect to continue your health coverage as a retiree, coverage will be provided under the Welfare Plan for you and/or your eligible dependents who are not Medicare eligible. When you and/or your eligible dependents become Medicare eligible, hospital, medical and prescription drug coverage will be provided under an Aetna Medicare Advantage program; life insurance, accidental death and dismemberment, and dental benefits will continue to be provided under the Welfare Plan.

The Welfare Plan requires that retired members and spouses of retired members who do not have employment based health coverage sign up for Medicare when first eligible. You and your eligible dependents become eligible for Medicare upon turning age 65, after receiving Social Security disability benefits for 24 months or when suffering from end-stage renal disease (kidney failure).

**If you are retired and receiving continued health coverage as a retiree under the Welfare Plan, whether based on exhaustion of your eligibility bank as an active member or self-payment of retiree premium, and fail to obtain Medicare coverage for yourself or your eligible dependents when eligible, claims will not be considered for coverage under the Welfare Plan.**

Once you or your spouse become Medicare-eligible, coverage under the Welfare Fund is provided under a Medicare Advantage plan through a contract between the Welfare Fund and Aetna Life Insurance Company. The Welfare Fund will automatically enroll you or your spouse in this plan for hospital, medical, and prescription drug coverage. Aetna will send all enrolled individuals a membership ID card, which is the only card to be used when receiving covered services (hospital, medical, pharmacy). In order to enroll an individual in the Aetna plan, he/she must have both Medicare Parts A and B. If you have Medicare because you have end-stage renal disease, you are eligible for enrollment in the Aetna plan starting with the 31<sup>st</sup> month of becoming Medicare eligible (for first 30 months the Welfare Plan is your primary coverage).

It is important that you contact Social Security several months prior to your Medicare eligibility so that your coverage under the Welfare Fund can be transitioned to the Aetna Medicare Advantage plan as of your Medicare-eligible date and you do not incur a gap in coverage. To sign up for Medicare Parts A and B, call Social Security at 1-800-772-1213/TTY: 1-800-325-0778, apply at [socialsecurity.gov/retirement](http://socialsecurity.gov/retirement) or visit your local Social Security office. Send the Pension Department a photocopy of your Medicare card as soon as you receive it. This photocopy can be mailed to: IUOE Local 825 Pension Fund, 65 Springfield Avenue, 2<sup>nd</sup> Floor, Springfield, NJ 07081 or faxed to: 973-774-1305. A spouse covered under a group health plan based on current employment who plans to delay signing up for Medicare until such employment or coverage ends must notify the Welfare Fund in writing. Coverage for this spouse will terminate. When spouse enrolls in Medicare at a later date he/she can request enrollment in the Aetna Medicare Advantage Plan.

**I have read the above information regarding the requirement for enrolling for Medicare Part A and B coverage and submitting a photocopy of my Medicare card to the Pension Department: Initial \_\_\_\_\_**

Non-Medicare eligible dependents will remain covered under the Welfare Fund. When Medicare eligible, they will be enrolled in the Aetna Medicare Advantage Plan.

Below are answers to some questions you may have about continued health coverage as a retiree. After you have read through the questions and answers, sign and date the acknowledgement at the end and return to the Pension Department.

**If I retire, will my dependents still be covered?** Yes. As long as they remain eligible, your dependents will be covered after retirement.

**Do I pay extra for my spouse or dependent children to be covered?** No. As a retiree, you pay one premium for family coverage. Your spouse and dependent children are covered at no additional cost provided they remain eligible.

**What happens if my spouse and I divorce post-retirement?** Your spouse is covered for as long as he/she remains your legal spouse. Your former spouse may be eligible for COBRA continuation coverage provided notice of divorce is supplied within 60 days of your divorce date.

**Will enrollment in the Aetna Medicare Advantage plan sponsored by the Local 825 Welfare Fund impact my or my spouse's participation in other plans?** Medicare rules don't allow individuals to participate in a group Medicare Advantage Medical and Prescription plan and an individual or employer-sponsored Medicare Part D prescription drug plan or another Medicare Advantage plan. If you're enrolled in any of these other plans, Medicare will cancel the other coverage when enrolled in the Local 825 Aetna Medicare Advantage Medical and Prescription Drug plan. Conversely, if you are enrolled in the Local 825 Aetna Medicare Advantage Medical and Prescription Drug plan first, Medicare will cancel this coverage when enrolled in any of the other plans. Coverage under a commercial prescription drug plan does not impact participation in other plans. If you want to opt out of automatic enrollment in the Local 825 Aetna Medicare Advantage plan, contact the Fund Office for an opt out form.

**When should I sign up for Medicare?**

You should contact Medicare about three months before turning age 65. Your initial enrollment period for Medicare Part A and/or Part B begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65. If you enroll the month you turn 65 or during the last three months of your initial enrollment period, the start date for Medicare coverage will be delayed. If you do not sign up during your initial enrollment period and you are not eligible for a Special Enrollment Period, you can sign up during the first three months of the calendar year (General Enrollment Period); coverage will begin July 1 and you may have to pay a higher premium for late enrollment. You may also be able to sign up for Medicare during a Special Enrollment Period provided you are age 65 or older and have had health insurance under an employer's group health plan because you or your spouse *currently* work. You can sign up for Medicare during a Special Enrollment Period (1) anytime you or your spouse is working and you have coverage under a group health plan based on that employment and (2) during the 8-month period that begins the month after the WORK ends or coverage ends, whichever occurs first. **It is important that you familiarize yourself with Medicare's enrollment rules and its definition of current employment.**

**How does other insurance work with the Aetna Medicare Advantage Plan?** Medicare payer rules decide whether other insurance or Aetna pays first. These rules provide:

- If you have coverage as a retiree from your or your spouse's former employment, Medicare pays first.
- If you are 65 or older and have group health plan coverage based on your or your spouse's *current* employment, the group health plan pays first.
- If you are under 65 and disabled and have group health plan coverage based on your or a family member's *current* employment, the group health plan pays first.
- If you have end-stage renal disease and have group health plan coverage, the group health plan generally pays first for the first 30 months after you become eligible to enroll in Medicare. Thereafter, Medicare pays first.

**Example:** You're 65 or older, retired, and receiving continued health coverage as a retiree under the Aetna Medicare Advantage Plan. You are also eligible for group health plan coverage based on your spouse's current employment. Your spouse's group health plan pays first and Aetna Medicare Advantage pays second.

**Since the existence of other coverage determines the order of benefit payment, you should tell your health care provider, hospital, and pharmacy as well as any plans under which you are covered about the existence of other coverage. Failure to do so may result in claims being denied for payment.**

**Once I become Medicare eligible, are any benefits still covered under the Welfare Fund?** The Welfare Fund will continue to provide your life insurance, accidental death and dismemberment, and dental benefits.

**Can I choose not to be enrolled in the Aetna Medicare Advantage Plan?** If you wish to opt out of enrollment in the Aetna Medicare Advantage Plan, call the Fund Office to request an opt out form. This form must be completed and returned to the Fund Office. The Aetna Medicare Advantage Plan replaces your coverage under the Welfare Plan. If you opt out of the Aetna plan, you won't be covered by the Welfare Plan and all your benefits will terminate, including the life insurance, accidental death and dismemberment, and dental benefits. You can still be covered by Original Medicare Parts A and B; you will have to find other supplemental coverage on your own (if desired); the cost of coverage deducted from your monthly pension check will cease.

I have read the above information regarding retiree health coverage and understand the requirement for timely enrolling for Medicare coverage and the impact the existence or absence of other coverage may have with regard to coverage under the IUOE Local 825 Welfare Plan.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**OPERATING ENGINEERS LOCAL 825 WELFARE FUND**

**SPOUSAL COVERAGE FORM**



Dear Member:

Please complete the following information and return this form.

1. **Member's Name & SSN:** \_\_\_\_\_

2. **Member's Phone #:** (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

3. Is your spouse currently eligible for Social Security Disability Benefits?  Yes  No  
***If yes, please provide a copy of the Social Security Disability Award Certification.***

4. Is your spouse employed?  Yes  No If "yes", please complete the following:

Your Spouse's SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

5. Is your spouse also covered under any group health insurance or group prepayment plan?  Yes  No  
If "yes", please complete the following: Is this single or family coverage?  Single  Family

	<b>Yes</b>	<b>No</b>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Prescriptions	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

**Please submit a copy of each insurance card, both front and back, for each insurance checked above.**

*If your spouse's insurance coverage has terminated, please forward a letter from her/his insurance carrier reflecting termination date.*

\_\_\_\_\_  
**Member's Signature**

\_\_\_\_\_  
**Date**

**OPERATING ENGINEERS LOCAL 825 PENSION FUND**

FEDERAL TAX WITHHOLDING FORM



**Federal Tax Withholding for Pension Payments**

If you wish to voluntarily start withholding Federal Income Tax from your pension payment, change the amount currently withheld, or stop withholding, please complete the form below and return to:

**Operating Engineers Local 825 Pension Fund**  
65 Springfield Ave, 2<sup>nd</sup> Floor  
Springfield, New Jersey 07081  
Fax: (973) 774-1305 / E-Mail: pension@825funds.org

Please refer to IRS Form W-4P for additional information and to IRS Publication 15 for current income tax withholding tables. Consult your tax professional for advice on tax withholding. Incomplete forms will not be processed. If no form is on file, withholding will default to Married with 3 Allowances.

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**Withholding Certificate for Pension Payments (W4-P)**

Payee Name, SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone, Cell, E-Mail: \_\_\_\_\_

1. \_\_\_\_\_ Check here if you do not want any federal income tax withheld from your pension. (Don't complete line 2, 3 or 4.)
2. \_\_\_\_\_ Check here to withhold a flat amount \$\_\_\_\_\_ or percentage \_\_\_\_\_% from each pension payment. (Don't complete line 3 or 4.)
3. \_\_\_\_\_ Check here for total number of allowances \_\_\_\_\_ and marital status \_\_\_\_\_ (Single, Married)
4. \_\_\_\_\_ Check here for an additional amount, if any, you want withheld from each pension payment. (Note: you can't enter an amount here without entering the number (including zero) of allowances on line 3.) \$\_\_\_\_\_ or \_\_\_\_\_%

Payee Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**OPERATING ENGINEERS LOCAL 825 PENSION FUND**

STATE TAX WITHHOLDING FORM



**State Tax Withholding for Pension Payments**

If you wish to voluntarily start withholding State Income Tax from your pension payment, change the amount currently withheld, or stop withholding, please complete the form below and return to:

**Operating Engineers Local 825 Pension Fund**  
65 Springfield Ave, 2<sup>nd</sup> Floor  
Springfield, New Jersey 07081  
Fax: (973) 774-1305 | E-Mail: pension@825funds.org

Note: Your State for withholding purposes will be your State of residence. Consult your tax professional for advice on tax withholding. Incomplete forms will not be processed. If no form is on file, withholding will default to Married with 3 Allowances.

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**Certificate of Voluntary Withholding for State Income Tax**

Payee Name, SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone, Cell, E-Mail: \_\_\_\_\_

1. \_\_\_\_\_ Check here if you do not want any state income tax withheld from your pension. (Don't complete line 2, 3 or 4.)
2. \_\_\_\_\_ Check here to withhold a flat amount \$ \_\_\_\_\_ or percentage \_\_\_\_\_% from each pension payment. (Don't complete line 3 or 4.)
3. \_\_\_\_\_ Check here for total number of allowances \_\_\_\_\_ and marital status \_\_\_\_\_ (Single, Married)
4. \_\_\_\_\_ Check here for an additional amount, if any, you want withheld from each pension payment. (Note: you can't enter an amount here without entering the number (including zero) of allowances on line 3.) \$ \_\_\_\_\_ or \_\_\_\_\_%

Payee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# OPERATING ENGINEERS LOCAL 825 PENSION FUND

## DIRECT DEPOSIT ENROLLMENT FORM

New Request  Change Request



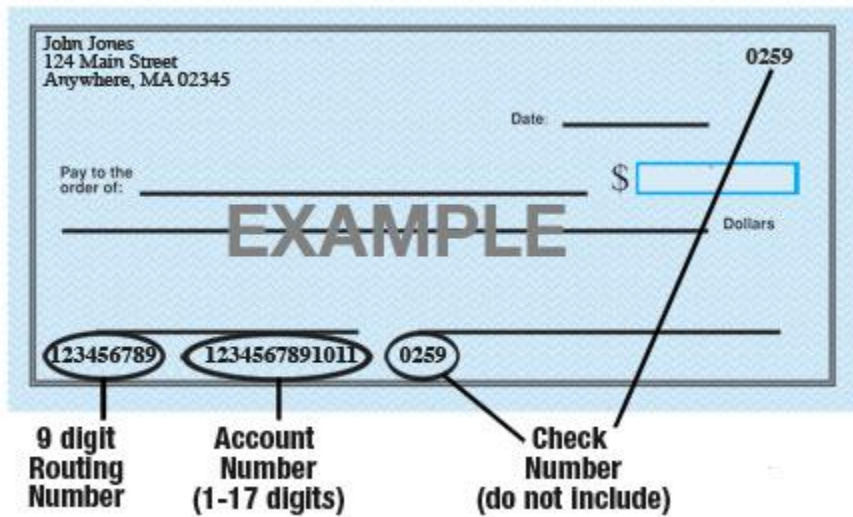
Payee Name, SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone, Cell, E-Mail: \_\_\_\_\_

\_\_\_ Please check if this is a change in your mailing address.



**Attach a voided check or bank statement to ensure accurate identification and confirm that the account is in the name (or joint name) of the Payee. Requests received without documentation will not be accepted.**

Name of Bank: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

Account #: \_\_\_\_\_

Type of Account:    Checking    Savings    (Circle One)

I hereby authorize Operating Engineers Local 825 Pension Fund (the "Fund") to make all pension payments due me to the bank indicated above for direct deposit into my account. To correct any overpayments credited to my account during or after my lifetime, I hereby authorize and direct the bank designated above to debit my account and to refund any such overpayment to the Fund. This authorization will remain in effect until the Fund receives further written notice from me, and the Fund has had reasonable opportunity to act on it.

Payee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE SEE INSTRUCTIONS ON OTHER SIDE**

## INSTRUCTIONS FOR DIRECT DEPOSIT

### INFORMATION

All identifying information should be completed, including the full name of the Payee. Payee refers to the retired plan participant, surviving spouse or beneficiary entitled to payment. The bank account specified must be in the Pensioner's name or in the Pensioner's name as part of joint account.

The name, routing number and the account number of the bank should be inserted in the space provided. Attach a voided check or bank statement to ensure accurate identification and that the account is in the name (or joint name) of the Payee. Requests received without documentation will not be accepted. Requests received for direct deposit to an account not in the Payee's name will not be accepted.

### SIGNATURE

This form should be signed and dated by the Payee. If the Payee is unable to sign this form, a duly appointed Power of Attorney may complete this form. Please attach a copy of the Power of Attorney paperwork if not already on file.

### PLEASE NOTE:

If you decide to have your payments via direct deposit, it is very important that you notify us of any error or change in address even though your payments are deposited into your bank account. This information is necessary in case we have to correspond with you. Payments may be suspended if we are unable to locate you.

Please return this completed form to:

Operating Engineers Local 825 Pension Fund  
65 Springfield Ave. 2<sup>nd</sup> Floor  
Springfield, NJ 07081

Phone: (973) 671-6800  
Fax: (973) 774-1305

Email: [pension@825funds.org](mailto:pension@825funds.org)