|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | |  | **BIRTH DATE:** | | {stdMbrDateOfBirth} | |
| **SPOUSE:** | {stdMbrSpouseFullName} | | |  | **BIRTH DATE:** | | {stdSpouseDateOfBirth} | |
| **RETIREMENT DATE:** | {RetDate} | **TYPE:** | Terminal Illness | | **YEAR :** | {yrs} | **HOURS:** | {hrs} |

To the Board of Directors of the Motion Picture Industry Pension Plan (“Pension Plan”) and the Motion Picture Industry Individual Account Plan (“IAP”) (collectively “the Plans”):

This is to notify you that I, **{stdMbrFullName}**, intend to retire from the Motion Picture Industry (“Industry”) and start my benefits from the Plans on the 1st of the month following approval by the Benefits/Appeals Committee.

**PLEASE READ CAREFULLY BEFORE SIGNING**

**I understand that:**

1. I am voluntarily electing to start my benefits from the Plans. Neither plan requires me to start my benefits.
2. Except as provided below, I will receive retirement benefits starting on my Retirement Date in accordance with my election of payment options under the Plans.
3. My Retirement Date and start date are subject to the approval of the Benefits/Appeals Committee as set forth in Article IV, Section 5 of the Pension Plan or Article V, Section 5 of the IAP Trust Agreement for the Disability Benefit.
4. Before any payment(s) can be made, I must provide to the Plans proof of my date of birth, Social Security number and, if married, my spouse's date of birth and marriage certificate. In addition, if applicable, I must provide a conformed copy(ies) of the final judgment with the property settlements and agreements and/or death certificate(s) for previous spouse(s) during my participation under the Plans to verify that my prior spouse(s) has no claim to any portion of my benefits.
5. I must advise the Plans in the event I receive Social Security Disability Benefits or when my benefits cease or I return to work in the Industry.
6. At the Plans’ request, I will provide evidence of my continuing Social Security Disability Benefits.
7. The Plans may review my benefit eligibility if my Disability Pension continues for more than two years from my start date.
8. For any Payroll Month in which I am re-employed in the Industry for 50 hours or more in a covered job classification, my Pension Plan benefits derived from employer contributions will be forfeited. However, the portion derived from my own contributions, if any, will continue. Benefits will not be suspended for any month beginning on or after April 1 following the year I reach age 70½. (This paragraph does not apply to the IAP.)
9. I will earn additional benefits in the Plans only if I work at least 870 Credited Hours in a Computation Year\* after my Retirement Date. Any benefits I earn in Computation Years on or after April 1 following the year I reach age 70½ will be reduced by the value of distributions I receive for months I work 50 or more hours in the Industry.
10. The benefit payable to me is subject to final verification, review and adjustment.

**PARTICIPANT’S CONSENT**

Under penalty of perjury, I certify that my current marital status is: Single Married Divorced

My citizenship status *(required for tax purposes)* is: U.S. Citizen U.S. Resident Alien Other

My signature on this document indicates that I have read and understand the terms and conditions of this application.

Participant’s Signature Date