December 17, 2019

{stdMbrFullName}

{x stdMbrAdrCorStreet1}

{x stdMbrAdrCorStreet2}

{x if stdIsUSA = 1}

{x stdDomesticStateInternationalCountry}

{x else}

{x stdDomesticStateInternationalCountry}

{x stdMbrAdrCountryDesc}

{endif}

**Re: Disability Pension Due to Terminal Illness**

Dear {stdMbrFullNameInProperCase}:

You notified the Plan Office that you are suffering from a terminal illness and wish to apply for the Disability benefits under the Motion Picture Industry Pension Plan (“Pension Plan”) and the Motion Picture Industry Individual Account Plan (“IAP”) (collectively “the Plans”).

Enclosed is the “Attending Physician’s Statement” to be completed by your physician. In addition, you must complete the application requesting the appeal for your Disability Pension benefits due to the terminal illness. The Plan Office will present your appeal to the Benefits/Appeals Committee, which meets once a month.

If you have any questions, please contact the Plans’ Retirement Services Division by email at rsd@mpiphp.org or by telephone at (818) 769-0007 x2499 between 8 a.m. and 5 p.m. Pacific Time, Monday through Friday.

Sincerely,

{stdLoggedInUserFullName}

Retirement Benefits

See your Summary Plan Description for additional information about the Plans. Benefits are subject to final verification, review and adjustment. If applicable, these amounts may be subject to change in accordance with any divorce or Qualified Domestic Relations Order (QDRO), which may or may not be on file. In the event of any inconsistency between any communications and the provisions of the Plans, the provisions of the Plans shall govern.

|  |  |  |  |
| --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | **BIRTH DATE:** | {stdMbrDateOfBirth} |
| **SPOUSE:** | {stdMbrSpouseFullName} | **BIRTH DATE:** | {stdSpouseDateOfBirth} |
| **TYPE:** | Terminal Illness |  |  |

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. If I do not receive a Social Security Disability Award after the year the Benefit Committee approved my Disability, then the Plans will again review my eligibility for Disability Pension.
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 may 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 Widowed

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

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| --- | --- | --- |
| **PARTICIPANT’S NAME** | **MPID** | **DATE OF BIRTH** |
| {stdMbrFullNameInProperCase} | {stdMbrParticipantMPID} | {stdMbrDateOfBirth} |

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| **PHYSICIAN’S INFORMATION** | | | | |
| **Name (please print)** | | | | |
|  | | | | |
| **Specialty** | | | **Medical License #** | |
|  | | |  | |
| **Address** | | **City** | **State** | **Zip** |
|  | |  |  |  |
| **Phone** | **Fax** | **Email** | | |
|  |  |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PHYSICIAN’S FINDINGS** | | | | | | | |
| Diagnosis: | |  | | | | |  |
| Date of initial disability: | | |  | | Date Participant was last examined by you: |  |  |
| Present condition (Clinical Status – Include initial evaluation and current status of patient): | | | | | |  |  |
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|  |  | | | | | |  |
| Is the patient currently diagnosed as terminally ill with a life expectancy of fewer than two years? | | | | | | | |
| Yes No | | | |  | | |  |
| Does the terminal illness prevent the Participant from engaging in gainful employment? | | | | | | | |
| Yes No | | | |  | | |  |
|  | | | | | | | |

**PHYSICIAN’S CERTIFICATION**

I, the undersigned, a practicing licensed physician, hereby certify under penalty of perjury, that my answers to the foregoing questions are complete and true to the best of my knowledge, information and belief.

**Physician’s Signature Date**

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| --- | --- | --- | --- |
| Please describe Participant’s job (**To be completed by Participant**): | |  |  |
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