August 9, 2021

{stdMbrFullName}

{x stdMbrAdrCorStreet1}

{x stdMbrAdrCorStreet2}

{x if stdIsUSA = 1}

{x stdDomesticStateInternationalCountry}

{x else}

{x stdDomesticStateInternationalCountry}

{x stdMbrAdrCountryDesc}

{x endif}

**Re: Late Retirement Pension**

Dear {stdMbrFullNameInProperCase}:

Enclosed is the **Retirement Application** you requested to convert your Required Minimum Distribution benefits to a Late Retirement Pension under the Motion Picture Industry Pension Plan (“Pension Plan”) Motion Picture Industry Individual Account Plan (“IAP”) and any merged Local plan under which you are eligible to retire (collectively “the Plans”).

If you have not already withdrawn your IAP benefit, you are required to receive it upon retirement. Please complete the enclosed IAP Benefit Option Form. If the single Lump Sum is chosen, you must also complete the Lump Sum Distribution Form.

To begin the application process for a Retirement Date of **{dtRetirementdate}**, the Plans must receive your completed, signed Retirement Application by**{istrSixtyDaysPriorDate}**.

If you decide to postpone your retirement after completing the application requirements, a signed **Cancelation Form** must be received by the Plans **before** **{Retirement Date}**. Otherwise, your retirement benefits will start on your selected Retirement Date, provided all requirements have been met.

If you have any questions, please contact MPI’s Participant Services Center by e-mail at [rsd@mpiphp.org](mailto:rsd@mpiphp.org), or call (855) ASK-4MPI Monday through Friday from 8 a.m. to 5 p.m., Pacific Time.

Sincerely,

{stdLoggedInUserFullName}

Retirement Benefits

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | | | **BIRTH DATE:** | | {stdMbrDateOfBirth} | |
| **SPOUSE:** | {stdMbrSpouseFullName} | | | | **BIRTH DATE:** | | {stdSpouseDateOfBirth} | |
| **RETIREMENT DATE:** | | {dtWdrwl} | **TYPE:** | Late Retirement |  |  |  |  |

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

This is to notify you that I,**{stdMbrFullNameInProperCase}**, intend to retire from the motion picture industry (the “Industry”) and start my benefits from the Plans including any merged Local plan under which I am eligible to retire on **{strRetirementDate}**.

**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. I previously commenced my Required Minimum Distribution benefit from the Plans. I request that this benefit be converted to a Late Retirement Benefit. The form of benefit will be in accordance with my previous election of payment options under the Plans.
3. I will be considered a Pensioner when I do not work in (or receive any consideration from) the Industry (whether or not my employer contributes to the Plans) for two complete calendar months immediately following my Retirement Date.
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(s) 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 pension benefit.
5. If I have not already withdrawn the IAP benefit, I am required to receive it upon retirement.
6. 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 1st 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.
7. By retiring, I will no longer be eligible for any active benefit rate increases effective after my Retirement Date.
8. The benefit payable is subject to final verification, review and adjustment.

**PARTICIPANT’S CONSENT**

I understand that this application must be received by the Plans at least two complete calendar months prior to my Retirement Date, *i.e.,* no later than **{dtSixtyDaysPrior}**,or it will not be accepted. If I want to cancel this application after returning it to the Plans by the initial deadline, the Plans must receive a completed, signed **Cancelation Form** prior to my Retirement Date.

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

**Medicare Coordination**

***Retired Participants Eligible for Medicare***

When you or your covered dependents are eligible for Medicare for any reason including disability or reaching age 65, whether or not you have retired and applied for Social Security benefits, you must be certain to enroll at your Social Security office for Medicare Part A and Part B benefits. You may enroll in Medicare any time during the three months preceding your 65th birthday and you should do so at your earliest opportunity. Medicare hospital insurance (Part A) provides inpatient hospital benefits and is free to you. Medicare medical insurance (Part B) pays for necessary doctor services, outpatient hospital services and other medical services but requires that you pay for coverage, either by being billed directly (if you are not retired) or by being deducted from your Social Security check (if you are retired). It is vitally important for you and your covered dependents to enroll because:

* If you or your covered dependents are Medicare-eligible and not enrolled in both Medicare Part A and Part B, you and your covered dependents **will not be entitled to any retiree medical/hospital and prescription drug coverage** from MPIHP. You and your covered dependents will only have dental and vision coverage through MPIHP.

***Medicare Parts A and B Enrollment***

You will need to contact your local Social Security office within 90 days before your 65th birthday to enroll in Medicare Parts A and B. If you are age 65 or older and have applied for and established your monthly Social Security benefit, you ordinarily do not have to file an additional application for Medicare coverage. Medicare will mail you a card indicating that you have coverage under Parts A and B. You pay Medicare a monthly premium for Part B coverage. Your premiums for Part B coverage are ordinarily deducted from your Social Security benefits, if you receive them. Contact your local Social Security office for more information on Medicare benefits.

Social Security Administration Toll-Free Number (800) 772-1213

***Dependent Spouse Age 65***

If your dependent spouse reaches age 65 prior to your 65th birthday and is not entitled to Social Security benefits as a result of his/her own employment, such spouse may be required to pay a monthly premium for Medicare hospital insurance (Part A). Be sure that prior to your enrolled spouse’s 65th birthday you check with your Social Security office for a determination regarding the requirement for such premium payments.

***Non-U.S. citizens Age 65***

All aliens who have reached age 65 must also check with their Social Security office to determine the requirements for Medicare hospital insurance (Part A). Spouses and aliens who are required to pay the premium for Medicare hospital insurance, must do so to be eligible under the Retiree Plan guidelines. The Retiree Plan will not duplicate any benefits which your spouse or you are legally entitled to receive under Medicare by payment of the Medicare premium.

***Medicare for the Disabled, ALS and End Stage Renal Disease***

Medicare coverage is also available for disabled people under age 65. This includes workers at any age, persons who become disabled before age 22, and disabled dependent widows/widowers (50 or over) who have been entitled to Social Security or Railroad Retirement Disability checks for two years or more. Also, people under 65 who have ALS or need long-term dialysis treatment for chronic kidney disease or require a kidney transplant can be covered by Medicare.

|  |  |  |  |
| --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | **YEARS:** | {QYrsRH} |
| **MPID:** | {stdMbrParticipantMPID} | **HOURS:** | {CHrsRH} |

**THIS NOTICE CONCERNS YOUR**

**MOTION PICTURE INDUSTRY RETIREE HEALTH PLAN (“the Plan”) BENEFITS**

{x if bstrHealthEligibleFlag = “Y”}

**MPI records reflect that you have met the requirements for Retiree Health Plan benefits.**

{else}

**In order to qualify for Retiree Health Plan coverage, you must have at least (a) 20 Qualified Years and 20,000 Credited Hours; or (b) 15 Qualified Years and 20,000 Credited Hours (provided you have at least 3 Qualified Years after the year you turn age 40, and at least 1 Qualified Year in any of the Plan years 2000 through 2015.). According to our records you have not met the requirements for Retiree Health Benefits.**

{x endif}

**Medicare Enrollment Requirement**

When you, your spouse, or any dependent becomes eligible for Medicare benefits due to reaching age 65 or upon disability, you and your Medicare eligible dependent must enroll through the Social Security Administration (SSA) in **Medicare Part A and Part B** benefits and maintain them for your lifetime. Medicare Part A provides free inpatient hospital benefits. In most cases Medicare Part B requires payment of a premium and covers necessary doctor’s services, outpatient hospital services, and other medical services and supplies not covered by Part A.

In cases of disability, you generally become eligible for Medicare two years after your date of entitlement for SSA disability benefits (this is not the date that you receive your first SSA disability payment, this is generally 5 months after your disability onset date as determined by SSA). However, in certain cases, you might become Medicare eligible before the two-year period.

**Important! You and any Medicare eligible dependents must enroll in Medicare**

**Part A and Part B at the time you become eligible.**

If you participate in an HMO (Kaiser or Health Net), you and your Medicare eligible dependents must notify the Plan and your HMO three months prior to becoming Medicare eligible. Enrollment forms will be required for each Medicare eligible enrollee. If you participate in the Anthem Blue Cross PPO plan, you and your Medicare eligible dependents will be required to enroll in the Anthem Medicare Preferred (PPO) Medical Plan.

No benefits will be payable under the Retiree Health Plan for eligible Medicare benefits that are not paid because you or your Medicare eligible dependent did not enroll, qualify, or submit claims for Medicare Parts A and B coverage.

For more information about Medicare’s Coordination of Benefits policy, please refer to your *Summary Plan Description for Retired Participants*, email MPI’s Participant Services Center at service@mpiphp.org or call toll-free (855) ASK-4MPI between 8 a.m. and 5 p.m. Pacific Time, Monday through Friday.

**Social Security Administration Toll-Free Number is (800) 772 –1213.**

**ACKNOWLEDGEMENT**

I acknowledge that I understand the above Medicare enrollment requirement. I understand that when I become eligible for Medicare Part A and Part B, Medicare will become my primary payer for health care and the Retiree Health Plan will not pay for benefits until I enroll.

Participant’s Signature Date

Spouse’s Signature Date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PARTICIPANT:** | {stdMbrFullNameInProperCase} | | **BIRTH DATE:** | {stdMbrDateOfBirth} | |
| **SPOUSE:** | {stdMbrSpouseFullName} | | **BIRTH DATE:** | {stdSpouseDateOfBirth} | |
| **TYPE:** | | {istrBenType} | **RETIREMENT DATE:** | | {dtWdrwl} |

**BENEFIT ELECTION**

|  |  |  |
| --- | --- | --- |
| **Initial One** | **Benefit Option** | **Payment Amount\*** |
|  | 1. **Life Annuity** (Default option for unmarried Participants) | **{PartIAPLifeAnnuity}** |
|  | 1. **Qualified Joint and 50% Survivor Annuity** (Default option for married Participants) | **{PartIAPJS50}** |
| *Spouse’s Benefit at Participant’s Death* | *{SpouseIAPJS50}* |
|  | 1. **Joint and 75% Survivor Annuity** | **{PartIAPJS75}** |
| *Spouse’s Benefit at Participant’s Death* | *{SpousetIAPJS75}* |
|  | 1. **Joint and 100% Survivor Annuity** | **{PartIAPJS100}** |
| *Spouse’s Benefit at Participant’s Death* | *{SpouseIAPJS100}* |
|  | 1. **Ten-Years-Certain and Life Annuity** | **{PartTenYr}** |
|  | 1. **Lump-Sum Payment** | **{PartIAPLumpSum}** |

**\* All amounts are an estimate based on current balances and marital status, and subject to verification before payment.** Benefit amounts will not be listed under the Joint and Survivor Annuity options if you are unmarried. The beneficiary for a Joint and Survivor Annuity must be the spouse to whom you are married at the time of retirement regardless of divorce or remarriage during retirement. The beneficiary for a Ten-Years-Certain and Life Annuity must be your spouse and/or children.

**BENEFICIARY DESIGNATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | | Relationship  Spouse Child |
| Social Security Number | Birth Date (MM/DD/YYYY) | Beneficiary Type  Primary Contingent %: | |
| Mailing Address | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | | | Relationship  Spouse Child |
| Social Security Number | Birth Date (MM/DD/YYYY) | Beneficiary Type  Primary Contingent %: | |
| Mailing Address | | | |

**PLEASE USE A SEPARATE SHEET OF PAPER TO DESIGNATE ADDITIONAL BENEFICIARIES**

**PARTICIPANT’S CONSENT**

I understand that I may only revoke this benefit election during the 30-day period immediately preceding my withdrawal date. I understand that, upon withdrawal, this benefit election is irrevocable. I certify that all of the foregoing information is true and correct.

Participant’s Signature Date

**SPOUSE’S CONSENT**

I acknowledge that if my spouse elects to receive benefits other than a Qualified Joint and 50% Survivor Annuity from the IAP, my signature below waives such Joint and Survivor Annuity. This consent is voluntarily given and no undue influence or coercion has been exercised in connection with my decision to give this consent.

Spouse’s Signature **(Must be Witnessed Below)** Date

|  |
| --- |
| Subscribed and sworn to before me on this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_, by {stdMbrSpouseFullName}, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.  (NOTARY STAMP)  **Signature of MPI Representative or Notary Public in and for said County and State** |

**MOTION PICTURE INDUSTRY INDIVIDUAL ACCOUNT PLAN (IAP)**

In general, unless a lump sum benefit is selected, the type of benefit payment will automatically be a monthly annuity benefit. If your balance is over $5,000, you may elect to receive the balance in a lump sum payment or a monthly annuity purchased from an insurance company.

1. **Life Annuity**

This option provides a monthly lifetime benefit payment to the Participant only. No benefit will be paid to any survivor. This is the only option available to unmarried participants with no children.

1. **Qualified Joint and 50% Survivor Annuity**

The Employee Retirement Income Security Act of 1974 (ERISA) requires a married Participant to retire with a Qualified Joint & 50% Survivor Annuity unless the Participant elects another available option with their spouse’s written consent. Under this option, you will receive a reduced monthly benefit (based on your age and your spouse’s age) throughout your lifetime. If you predecease your spouse, a lifetime monthly benefit will continue to be paid to your surviving spouse at an amount equal to one-half of the monthly benefit received while you were living. Regardless of divorce or remarriage during retirement, the Joint & 50% Survivor Annuity must be paid to the spouse you were married to on your retirement date.If your spouse predeceases you after your retirement date, the Joint & 50% Survivor Annuity will continue for your lifetime at the same reduced monthly amount; no benefit will be paid to any survivor, including a new spouse if you remarry after retirement.

1. **Joint and 75% Survivor Annuity**

This option is similar to the Qualified Joint & 50% Survivor Annuity except that there is less of a reduction in benefit to your surviving spouse in the event of your death. In the event of your death, a lifetime monthly benefit will continue to be paid to your surviving spouse at an amount equal to 75% of the monthly benefit received while you were living. The monthly benefit payment during your lifetime is lower than that received through the Qualified Joint & 50% Survivor Annuity.

1. **Joint and 100% Survivor Annuity**

This option is similar to the Qualified Joint & 75% Survivor Annuity Benefit except that there is no reduction in benefit to your surviving spouse in the event of your death. The monthly benefit payment during your lifetime is lower than that received through the Qualified Joint & 75% Survivor Benefit.

1. **Ten-Years-Certain and Life Annuity**

This option provides you with a monthly lifetime Pension benefit. In the event of your death within 10 years of your retirement date, your beneficiary will receive the same monthly benefit amount for the remainder of the 10-year period. Following this 10-year period, the benefit payments to your beneficiary will permanently cease. If you die after the 10-year period following your retirement date, no benefit will be provided to your beneficiary. If you retire under this option and are re-employed, the 10-year period shall not be increased by the re-employment period.

1. **Lump-Sum Payment**

If your balance is $5,000 or less, your benefit will be automatically paid in a single lump sum. If your balance is over $5,000, you may elect, with spousal consent, to take the entire value of the benefit in a single lump sum. If you elect a lump sum and your balance is equal to or greater than $200, it is subject to a mandatory 20% Federal tax withholding, unless you roll it over into an IRA or other qualified plan.

**Annuity Purchase Option under the lAP:**

If you elect from Option 1,2, 3, 4 or 5, the Plan Office will purchase an annuity for you from an insurance company using your account balance. You will receive a monthly benefit from the insurance company.

|  |  |  |
| --- | --- | --- |
| ***Pursuant to the provision of the Motion Picture Industry Pension and Individual Account Plans (the ''Plans''), the Plans are authorized to distribute the funds in accordance with the Option I have selected below. I understand that the distribution process may be delayed or cancelled if this form along with the application is not received by the Plan Office within 60 days from your application date.*** | | |
| **RECIPIENT’S NAME** | **MPID** | **DISTRIBUTION AMOUNT** |
| {stdMbrFullNameInProperCase} | {stdMbrParticipantMPID} | *{PartLumpSumBenAmt} (through* *{LumpSumYear})* |

|  |  |
| --- | --- |
| **Distribution Type:Pl** | ***{DistributionType}*** |
| Please refer to the Information about the tax treatment of distributions in the accompanying Special 402(f) Tax Notice Regarding Plan Payments. The Plans strongly recommends you discuss the distribution options below with a tax professional. | |
| **Check only one option under Section A.**  **If you choose option 2 or 3, page 2 must be completed by the custodian of your IRA or other qualified plan.** | |
| If you do not elect to rollover all or a portion of your distribution directly to an IRA or other qualified plan, the Plans will automatically withhold 20% in federal income taxes from that distribution. | |

|  |
| --- |
| **SECTION A: Distribution Type Election** (select only one) |
| **Option 1:** Please issue a check for the balance payable to me. I do not elect a direct rollover of my distribution. I understand that mandatory 20% federal income tax and 2% California State income tax (if elected) will be withheld. |
| *{x if IsRETR = 1} To qualify for the options below, the taxable portion of the payment must be $750 or more.*  *{else} To qualify for the options below, the taxable portion of the payment must be $200 or more.*  *{x endif}* UV&HP) are non-taxable. Interest on these items is taxable. {x |
| {  **Option 2:** I elect to rollover the entire distribution into my IRA or qualified plan.  **Option 3:** I elect to rollover a portion of my distribution directly into my IRA or qualified plan. The amount I would like to rollover is indicated in the Rollover Amount box on the top of page 2. I understand that a separate check will be issued for the balance of the taxable portion, less applicable federal and state income tax withholding, plus the entire non-taxable portion, if any.  **My Trustee/Custodian and I must complete page 2** |

|  |
| --- |
| **SECTION B: Tax Resident Status** |
| My citizenship status is *(required for tax purposes)*: U.S. Citizen or Resident Alien Non-Resident Alien\*  *\* IRS Form W-8 is required for non-resident alien claiming tax treaty benefits.* |

|  |
| --- |
| **SECTION C: State Income Tax Withholding Election** (for California residents only) |
| I understand that unless I select the box below, 2% California State income tax will be withheld from any portion of my distribution that is not rolled over to a qualified plan. I understand that my actual federal or state income tax liability may exceed the amount withheld by the Plans from the distribution to me. I understand that I may be subject to tax penalties under the estimated tax payment rules if my estimated tax payments and withholding are inadequate. |
| Do NOT withhold California state tax *(I understand this choice does not relieve me of any tax liability)* |

**RECIPIENT’S CONSENT**

My signature on this document indicates that I authorize the Plans to distribute the funds in accordance with the option I selected above and that I have reviewed the Plans’ *Summary Plan Description* terms and conditions as well as the Special Tax Notice 402(f) Regarding Plan Payments.

If I elect Options 2 or 3, I authorize the IRA or employer plan identified on page 2 to accept a rollover on my behalf. I understand that

my check will be processed based on the information herein. I will notify the Plans if there are any changes to this information.

Recipient’s Signature Date

**PAGE 2: ROLLOVER ACCOUNT INFORMATION AND AUTHORIZATION**

To be completed only if choosing Option 2 or Option 3

|  |  |  |
| --- | --- | --- |
| **RECIPIENT’S NAME** | **MPID** | **ROLLOVER AMOUNT** |
| {stdMbrFullNameInProperCase} | {stdMbrParticipantMPID} |  |

|  |
| --- |
| Must be completed by the custodian of your IRA or qualified plan |

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION D: Rollover Account** | | | |
| **Type of IRA or Plan:**  IRA – Sec 408(a) Roth IRA – Sec 408(a)  Annuity – Sec 408 (b) Annuity – Sec 403(a) Annuity – Sec 403(b)  Qualified Trust/Plan – Sec 401(a) Government Deferred Compensation Plan – Sec 457(b) | | | |
| **MAKE CHECK PAYABLE TO:** | (Trustee/Custodian of IRA/Qualified Plan) | | |
|  | | |
| **Account Number** (Please DO NOT use Social Security Number) | | | |
|  | | | |
| **PAYMENT HANDLING INSTRUCTIONS** | | | |
| **Check will be mailed to:** | | | |
| **IRA or Plan Contact Name** (Required if Account Number field is not completed) | | | |
|  | | | |
| **Address** | | | |
|  | | | |
|  | |  |  |
| **City** | | **State** | **Zip** |
|  | |  |  |
| I declare that the IRA or employer plan identified above will accept a rollover on behalf of the recipient hereof. I declare that I am authorized to act on behalf of the financial institution, the IRA or employer plan identified above. | | | |
| Trustee/Custodian’s Signature Date | | | |
| **Trustee/Custodian’s Name** | | **Title** | |
|  | |  | |
| **Email** | | **Phone** | |
|  | |  | |