

PAYMENT FROM THE DEFERRED SALARY PLAN

You should refer to your summary plan description booklet as to your eligibility to receive distribution from the Plan. Listed below is the required documentation that must be attached to this application in order for payment to be made to you. **The Plan reimburses benefits for up to one year after the event or date the service is rendered.**

1. **Supplementary Unemployment, Disability or Workers' Compensation Benefits**

In order to be eligible, you must be receiving Unemployment, Disability or Workers' Compensation Benefits. The applicant must furnish a photocopy of the Unemployment, Disability or Workers' Compensation check stub to the Plan. You must notify the Plan when you return to work.

2. **Supplementary Economic Assistance Benefits**

In order to receive payment for unreimbursed hospitalization, medical, surgical, prescription drug, or dental expenses, the applicant must first submit bills to all other eligible plans, as required. Submit the denial or Explanation of Benefits along with the form "A" or form "B" portion of this application. The Plan will also allow for reimbursement of COBRA premiums, Medicare Part "B" premiums, long term care premiums paid to an insurance company, subject to Internal Revenue Code limits, and certain over-the-counter drugs.

Individual bills for any of the above should be accumulated until the total expenses equal or exceed \$100.00 or you may submit a lesser amount at the beginning of each December, but no later than 12 months from the date incurred.

In order to obtain reimbursement for a COBRA premium payment, the applicant is obligated to include a copy of the canceled check for the participant, a divorced spouse or dependent child.

In order to obtain reimbursement for a Medicare Part "B" premium payment, the applicant must submit Form SSA-1099 on an annual basis.

In order to obtain reimbursement for Long Term Care premiums paid to an insurance company, you must submit a copy of the premium statement along with a copy of both sides of the canceled check.

Only those contributions made more than two years prior to the distribution date are available for COBRA, Medicare or Long Term Care premiums, unless the applicant has been a participant in this Plan for at least five years.

3. **Supplementary Financial Assistance Benefits**

The applicant must submit an original delinquent mortgage payment coupon, rent bill or notarized Landlord Form along with proof of current unemployment. Additional information may be requested. This benefit is subject to a remaining account balance of \$2,000.00.

4. **Supplementary Vacation and Holiday Benefits**

The applicant will have to provide a letter from the employer indicating the vacation dates, unless already on file with this office, or a letter from the participant when requesting payment for a holiday. Only those contributions made more than two years prior to the distribution date are available, unless the applicant has been a participant in the Plan for at least five years.

5. **College Tuition and Non-College Private School Tuition Reimbursement**

The applicant must attach an original itemized paid bill on school letterhead, including the student's name, semester/school year and dollar amount paid. Tuition bill must be signed by a financial representative of the school and must bear the school's seal or stamp. Reimbursement may be requested on an annual or semi-annual basis. This benefit is subject to a remaining account balance of \$2,000.00.

6. **Jury Duty Benefit**

Members who are *not* eligible for the regular Jury Duty benefit from the Educational and Cultural Trust Fund must attach the original receipt from the court as proof of serving jury duty.

7. **Funeral Leave Benefit**

The applicant must attach a certified death certificate. This benefit is limited to immediate family: spouse, parent, spouse's parent, child (natural, adopted, or dependent), grandchild, brother and sister.

8. **Adoption Expenses**

Qualified adoption expenses, including court costs, attorney and other related fees, may be reimbursed if related to the adoption of a child under the age of 18. Original paid bills, as well as a copy of the final adoption document, are required. The maximum withdrawal is \$10,000.00, subject to a remaining account balance of \$2,000.00.

Important:

- Distributions from the Plan are subject to 20% federal income tax withholding, as required by IRS regulations.
- Withdrawals by a participant who is still working in the electrical industry and is younger than 59 ½ or by a participant who withdraws from the industry prior to age 55 are subject to the IRS penalty tax of 10%.
- There is **no** 10% IRS Early Withdrawal Tax when a payment is made to an active participant who is 59 ½ or older or to a participant who retires under the provisions of the Pension Trust Fund of the Electrical Industry.

FORM "B" PRESCRIPTION AND/OR OVER-THE-COUNTER DRUG RECORD

**DEFERRED SALARY PLAN OF THE ELECTRICAL INDUSTRY
158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, NY 11365**

INSTRUCTIONS: *Please read carefully:*

List your PRESCRIPTION AND/OR OVER-THE-COUNTER DRUG RECEIPTS ON THIS FORM. *For a list of covered and non-covered over-the-counter drugs, please see the back of this form.*

List bills in date order. Bills will not be accepted unless properly listed on this form. This form will not be accepted unless accompanied by original itemized receipts or an Explanation of Benefits voucher. Do not send in duplicate bills or bills previously submitted and paid through any other employee benefit plan. Return application, this form and receipts, or an Explanation of Benefits voucher in the enclosed self-addressed envelope. **SIGN THIS FORM** at the bottom.

Date of Service	Name of Drug or Product	Patient's Name	Relationship of Patient (Self, Spouse, Child)	Amount to be Reimbursed
				\$

Total Amount to be Reimbursed \$ _____

NOTICE

Any intentional statement of incomplete and/or incorrect information may result in disciplinary action including the institution of a civil and/or criminal proceeding. I have read the foregoing Notice and I certify to the completeness and accuracy of this application

Print Participant's Name

Participant's Signature

Social Security Number

Date

Covered Over-the-Counter Medications include:

Allergy Medicine	Analgesics
Antihistamines	Antacids
Anti-Diarrhea Medication	Aspirin
Calcium Supplements (only if recommended by a doctor for a specific condition)	Cold Medicine
Contact Lens Solution	Cough Drops
First Aid Cream (Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatments)	Hemorrhoidal Medications
Lactose Intolerance Pills	Laxatives
Menstrual Cycle Medications	Motion Sickness Pills
Muscle/Joint Pain Relief (i.e. Ben-Gay, Tiger Balm)	Nasal Sinus Spray
Nicotine Gum/Patches	Pain Reliever
Pedialyte	Reading Glasses
Rubbing Alcohol	Sinus Medications
Smoking Cessation Products	Throat Lozenges
Visine	Wound Care Products

Over-the-Counter Medications not covered include but are not limited to:

Chapstick	Cosmetics
Cotton balls/swabs	Face Cream
Hair Loss Medication/Rogaine	Medicated Shampoos/Soaps
Moisturizers	One-a-Day Vitamins/Vitamins for General Health
Suntan Lotion	Toiletries
Toothbrushes	Toothpaste
Teeth Whitening Products	Topical Creams
Nutritional Supplements	Nasal Sprays (for snoring)
Sleeping Aids	Pre-Natal Vitamins
Pregnancy Tests	