

# San Mateo County Electrical Construction Industry Retirement Plan

## ADMINISTRATIVE OFFICES

6800 SANTA TERESA BLVD STE#100 SAN JOSE, CA 95119

Ph: (408)288-4400 Fax: (408)288-4569

## **Required Minimum Distribution**

The IRS mandates a Required Minimum Distribution (RMD) to be processed each year for participants that have attained the age of 72 (70 ½ if you reach 70 ½ before January 1, 2020). You must take the RMD by **December 31st**. By completing this application, you are consenting for your distribution to be processed accordingly.

Participants Name: \_\_\_\_\_ Soc. Sec. Number: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse Name: \_\_\_\_\_

### **Delivery Instructions (Please select one):**

☐ Direct Deposit to my financial institution on file with \_\_\_\_\_ (Bank) Last Four of Acc.# \_\_\_\_\_

☐ Send Payment by Check to the address listed above.

### **Federal Tax Withholding:**

I elect to have the following Federal Income Tax withholding from my Required Minimum Distribution:

☐ No Federal Income Tax Withholding

☐ Voluntary Withholding at 10%

☐ Other \_\_\_\_\_

### **California State Tax Withholding:**

I elect to have the following (California State Only) State Income Tax withholding:

☐ No California Income Tax Withholding

☐ Other \_\_\_\_\_

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

**If you are married, please complete the Spousal Waiver form attached. The form must be notarized.**

## SPOUSAL WAIVER FORM

### SAN MATEO COUNTY ELECTRICAL WORKERS JOINT TRUST FUNDS

#### FORM FOR SPOUSE TO CONSENT TO PARTICIPANT'S ELECTION TO RECEIVE THE REQUIRED MINIMUM DISTRIBUTION (RMD) IN A FORM OTHER THAN STANDARD JOINT AND 50% TO SPOUSE

For a married participant, federal law (ERISA) requires that the Plan's standard form of retirement is a Joint and 50% Survivor Annuity. The Joint and Survivor 50% Annuity provides a reduced lifetime benefit for a married participant, and upon the participant's death, 50% of the monthly pension amount will continue being paid to the surviving spouse for the spouse's lifetime. Pension Benefits will be paid in this form unless the spouse signs this waiver form consenting to an alternate benefit option. Spouse's signature must be notarized.

I declare under penalty of perjury that \_\_\_\_\_ is my spouse.  
(Participant's Name)

I hereby consent to my spouse's election to receive our **Required Minimum Distribution** in a form other than the "Standard Joint and 50% to Spouse Benefit". I understand that this means that if my spouse predeceases me, I will not receive the standard survivor's annuity I would otherwise receive as required by law. I further understand that this waiver is irrevocable after 90 days of the date this form was signed below. However, **I do understand that any remaining balance upon my spouse's death would be paid to me as the beneficiary.**

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

\_\_\_\_\_  
Participant's Name (Please Print)

\_\_\_\_\_  
Spouse's Name (Please Print)

\_\_\_\_\_  
Social Security No.

\_\_\_\_\_  
Social Security No.

Spouse's Signature: \_\_\_\_\_  
(Must be witnessed by a Notary Public or Plan Representative)

#### TO BE COMPLETED BY PLAN REPRESENTATIVE

Signature of spouse witnessed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ in the presence of:

\_\_\_\_\_  
Plan Representative Signature

Form of I.D. \_\_\_\_\_

\_\_\_\_\_  
Print Name

See Next Page for Notarization

**CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT****CIVIL CODE § 1189**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California )

County of \_\_\_\_\_ )

On \_\_\_\_\_ before me, \_\_\_\_\_,  
*Date Here Insert Name and Title of the Officer*

personally appeared \_\_\_\_\_  
*Name(s) of Signer(s)*

\_\_\_\_\_ ,  
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_  
*Signature of Notary Public*

*Place Notary Seal Above*

**OPTIONAL**

*Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.*

**Description of Attached Document**

Title or Type of Document: \_\_\_\_\_ Document Date: \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Signer(s) Other Than Named Above: \_\_\_\_\_

**Capacity(ies) Claimed by Signer(s)**

Signer's Name: \_\_\_\_\_

☐ Corporate Officer - Title(s): \_\_\_\_\_☐ Partner – ☐ Limited ☐ General☐ Individual ☐ Attorney in Fact☐ Trustee ☐ Guardian or Conservator☐ Other: \_\_\_\_\_

Signer Is Representing: \_\_\_\_\_

Signer's Name: \_\_\_\_\_

☐ Corporate Officer - Title(s): \_\_\_\_\_☐ Partner – ☐ Limited ☐ General☐ Individual ☐ Attorney in Fact☐ Trustee ☐ Guardian or Conservator☐ Other: \_\_\_\_\_

Signer Is Representing: \_\_\_\_\_

**SAN MATEO COUNTY ELECTRICAL WORKERS LOCAL 617**  
**ELECTRONIC FUNDS TRANSFER (EFT) APPLICATION**

---

***Please attach voided check here.***

---

**NAME OF PAYEE:** \_\_\_\_\_

**SSN #:** \_\_\_\_\_ **TELEPHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**NAME OF FINANCIAL INSTITUTION:** \_\_\_\_\_

I request that my pension benefit check be deposited electronically into:

☐ **Checking Account #** \_\_\_\_\_

☐ **Savings Account #** \_\_\_\_\_

---

I agree with and understand the following:

- (A) This Direct Deposit request is to remain in effect until written notification is given to the plan office or the plan office no longer offers Direct Deposit via ***Electronic Funds Transfer***.
- (B) It is my responsibility to provide any bank changes (account #, name, or address) to the plan office to assure timely receipt of my benefit.
- (C) If my home address changes, I will advise the plan office of the changes in writing.
- (D) There will be a transaction reversal for any amount deposited into my account that I am not entitled to receive.

**Signature:** \_\_\_\_\_

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

---

For office use only:      (   )   Add      (   )   CA  
                                 (   )   Change      (   )   CA/Nacha Screen   (   )   Delete