MEBA PENSION TRUST
APPLICATION & INSTRUCTIONS FOR STAFF PENSION BENEFITS

Instructions

A. Complete all the information on the application. Please be sure to sign and date the application where indicated.

B. Complete and attach the following forms to your application. If any of these forms are missing from your application packet, please visit the Plan Office website at *www.mebaplans.org* to obtain these forms.
   1. Permanent Data Form No. 2
   2. Beneficiary Form
   3. Direct Deposit Form

C. You are required to provide two documents for proof of your date of birth. Attach the following documents to your application (Please disregard if these documents have been submitted to us previously). Acceptable documents include:
   1. A certified copy of a birth certificate or baptismal certificate for both you and your spouse.
   2. Original driver's license and/or passport.
   3. Original certificate of marriage or certified copy of the same.

   Original documents and certified copies will be returned to you.

D. Provide a statement from your Staff Plan Employer providing your last day on payroll.

E. When you have completed the above steps, mail your application and all required documents to the Plan Office, or file your application in person to the Plan Office in Baltimore.

Note: The Plan Office may request that you furnish additional forms necessary to complete your application. These forms will be mailed to you as needed. It is extremely important that you keep the Plan Office advised of your mailing address during the application process.

MEBA PENSION TRUST
1007 EASTERN AVENUE
BALTIMORE, MD 21202-4345

Member Name			
	Last Name	First Name	Initial
Date of Birth	☐☐-☐☐-☐☐☐☐ Month Day Year		
Social Security Number	☐☐☐-☐☐-☐☐☐☐		
Home Telephone Number	(Area Code:) ☐☐☐ - ☐☐☐☐		
Cellular Phone Number	(Area Code:) ☐☐☐ - ☐☐☐☐		
Permanent Address ***(Home of Record):***	Number & Street		
	City, State, Zip		
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		
Spouse's Name			
	Last Name	First Name	Initial
Spouse's Social Security Number	☐☐☐-☐☐-☐☐☐☐		

Is a former spouse or dependent entitled to receive a portion of your pension benefits pursuant to a state domestic relations order, consent, and judgment of decree? ☐ YES ☐ NO

DATE YOU WANT PENSION BENEFITS TO COMMENCE: _____

Your effective date of pension will be the later of:

1. The first of the month following the month in which this application is filed, or.
2. The first of the month following the month in which you cease all Covered Employment and have completed your last vacation period.

Are you applying for a Disability Pension? ☐ YES ☐ NO
Be advised that Disability Pensions are subject to an annual earned income limitation of $36,000.

If yes, attach your Social Security Administration Award of Disability Pension to this Application.

I hereby certify that all the information contained in this Application is true and correct to the best of my knowledge and belief and that all documents included with this Application are bonafide originals or true copies of the originals. I understand that a false statement could disqualify me from Pension Benefits.

_____ _____
Applicant's Signature **Date**

REJECTION OF SURVIVOR OPTION ELECTION FORM

SECTION I

[ ] I am single. I understand that I will receive my full pension benefit in the form of a single life annuity.

[ ] I am married and wish to REJECT ALL SURVIVOR OPTIONS and receive my full pension benefit in the form of a straight life annuity when I retire. (Requires spousal consent – Section II.)

[ ] I am married and wish to REJECT ALL SURVIVOR OPTIONS and receive my full pension benefit in the form of a Lump Sum Distribution when I retire. (Requires spousal consent – Section II.)

[ ] I wish to provide pension benefits to my spouse under the 50 Percent Regular Option. (Spousal Consent not required.)

_____ _____

Applicant's Signature **Date**

SECTION II

TO BE COMPLETED BY PARTICIPANT'S SPOUSE

I, the spouse of _____, a participant under the Plan, understand that if my spouse retires under the Plan, he or she will be entitled to receive benefits in the form of a qualified joint and survivor annuity, which is the 50 Percent Regular Option under the Plan, and under which benefits will be payable for his or her life and thereafter 50% of those benefits will be payable for my life, if I survive him or her. I understand that my spouse has elected to waive the qualified joint and survivor annuity and I hereby consent to such election. As a result, I acknowledge that the effect of such election, in the event of my spouse's death after his or her retirement, is that I will not be eligible to receive any pension benefits under the Plan.

_____ _____

Spouse's Signature **Date**

STATE OF }
}
COUNTY OF }

On the _____ day of _____, 20____ before me personally came _____ to me known to be the spouse of _____, and such spouse acknowledged to me that he/she executed the foregoing document.

Instructions for Completing Permanent Data Forms

You must complete a Permanent Data Form if you are a new Participant, if you are adding a Dependant, if your marital status changes, or if your dependant's eligibility status changes.

The following documents must be included with your completed Permanent Data Form:

Married

- If you are married – a copy of your marriage certificate.
- If your spouse has other coverage, please forward a copy of your spouse's medical/dental/optical insurance card(s), so that the Plan can properly coordinate benefits.

Children

- Biological children – a copy of each child's birth certificate.
- Adopted children – a copy of each child's adoption papers and birth certificate.
- Stepchildren – a copy of each child's birth certificate, a copy of your most recent IRS tax filing, a copy of that part of your spouse's divorce decree that assigns responsibility for the stepchild's medical care.
- Grandchildren - a copy of each child's birth certificate, proof of legal custody awarded by a court or state agency, a copy of your most recent IRS tax filing, (additional documentation may be required).

Dependant Parents

- Dependant Parents – a copy of your most recent IRS tax filing as proof that you claim your parent as a dependant on your tax return. You will be required to provide proof of support of your parent(s) annually.

Your parent(s) may be covered as a dependant only if:

(1) you do not have a spouse, you do not have natural or adopted children under the age of 26, and you do not have stepchildren under age 19 (or 23, if full-time students); and

(2) you contribute at least one-half of the support of the parent being claimed as a dependant, claim your parent as a dependant on your IRS tax return, and you submit a copy of your most recent IRS tax filing as proof of support.

Additional Requirements for Adult Children (over age 18)

Biological and Adopted Children Age 19 through 25

- Your biological and adopted adult children under the age of 26 may be covered as a dependant.

Stepchildren and Grandchildren

- Your stepchildren and grandchildren age 19 through age 22 may be covered as a dependant provided they are full-time students.
- Student status forms are available from the Plan Office or on the Plan website (www.mebaplans.org).
- You are required to verify full-time student status for each stepchild and/or grandchild each year.

If you or any of your dependents are eligible for Medicare, you must provide a copy of you and/or your dependent's Medicare card.

Change in Marital Status

Marriage

- If you are single and become married, you must notify the Plan Office and submit a copy of your marriage certificate with your new Permanent Data Form to enroll your new spouse.

Divorce or legal separation

- If you are married and become divorced or legally separated, you must notify the Plan Office immediately and submit a copy of your divorce decree, legal separation agreement or your written agreement to live separately within 30 days, along with your new Permanent Data Form.

- If you are divorced and are keeping your children as dependants in the Plan, you must provide additional information about other coverage the children may have, such as through your former spouse (or his or her new spouse, if remarried), so that the Plan can properly coordinate benefits. If included in your divorce decree, a copy of the portion that assigns responsibility for medical care may be needed to determine order of payment.

Address and Address Changes

- If you use a PO Box as either your permanent address or your mailing address, you must also provide a physical address.
- If you are advising the Plan of a change of address only and have no other changes to make you can complete a new Permanent Data Form or you can simply notify the Plan Office in writing of the address change. Include your name and social security number. The Participant must sign this notification in order to allow the Plan Office to change your address.

IMPORTANT - When Coverage Terminates

If you and/or your dependant no longer meet the eligibility requirements your coverage and/or your dependant's coverage will end. You are required to notify the Plan Office in writing and within 30 days of events that impact your and/or your dependant's eligibility under the Plan. Events that may lead to ineligibility and a loss of coverage under the Plan include, but are not limited to:

- Failure to report a divorce;
- Failure to report a legal separation;
- Failure to report a child's eligibility for other coverage, including the availability of such coverage;
- For stepchildren and grandchildren, failure to report a change in student status, a change in residency or a change in support;
- For stepchildren and grandchildren, failure to report a child's marriage;
- For grandchildren, failure to meet the grandchild eligibility rules; and
- Failure to pay any required premiums (e.g., COBRA, pensioner contributions, Alternate Plan premiums) timely.
- For Pensioners, return to work under certain circumstances without the permission of the Trustees.

If you do not timely notify the Plan Office of an event that causes a change in your or your dependant's eligibility under the Plan, you will be required to reimburse the Plan for benefits that were paid after your and/or your dependant's coverage terminated.

In addition, your or your dependant's coverage under the Plan may be terminated retroactively in the case of fraud or intentional misrepresentation.

MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (6322) * 410-547-6665 (Fax) * www.mebaplans.org

PERMANENT DATA FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name	Last Name First Name Initial		
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	☐ District No. 1-PCD, MEBA ☐ Plan Employee ☐ Union Employee ☐ Other:		
Active/Pensioner (Check One)	☐ Active ☐ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		
Date Married, Widowed, Divorced or Legally Separated (mm/dd/yyyy)		☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	
Permanent Address (Home of Record):	Number & Street		
	City, State, Zip		
Mailing Address (if different than Permanent Address above):	Number & Street		
	City, State, Zip		

DEPENDANTS TO BE ADDED TO YOUR MEDICAL COVERAGE (LIST FULL NAMES)

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐ Spouse ☐ Child ☐ Adopted Child ☐ Stepchild ☐ Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐ Yes ☐ No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

Revised 05/2020

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

LAST NAME FIRST NAME INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT
			☐Child ☐Adopted Child ☐Stepchild ☐Grandchild	☐ Yes ☐ No

If dependant is an adult child/adopted child, is he or she eligible for Employment Based Coverage? (check one) ☐Yes ☐No..
If eligible for Employment Based Coverage, complete the following sections

Child's Employer Name	Child's Employer Address	Child's Employer Phone
Child's Spouse's Employer Name	Child's Spouse's Employer Address	Child's Spouse's Employer Phone

(Attach a separate sheet to your Permanent Data Form if you have more than four Dependants)

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

Revised 05/2020

Instructions for Completing Beneficiary Designation Form

You must complete a Beneficiary Designation Form if you are a new Participant in the Plan or if you are changing your beneficiary for life insurance.

Changing Your Beneficiary for Life Insurance

- A new Beneficiary Designation Form must be completed in its entirety.
- The Beneficiary Designation Form **must be signed** for the change of beneficiary to become effective.

MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (6322) * 410-547-6665 (Fax) * www.mebaplans.org

BENEFICIARY DESIGNATION FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name			
	Last Name First Name Initial		
Social Security Number			
Date of Birth (mm/dd/yyyy)		Sex (Select one)	○ Male ○ Female
Home Telephone Number	(Area Code:)		
Cellular Phone Number	(Area Code:)		
E-mail address (If applicable)	@		
Affiliation (Check One)	☐ District No. 1-PCD, MEBA ☐ Plan Employee ☐ Union Employee ☐ Other:		
Active/Pensioner (Check One)	☐ Active ☐ Pensioner	If Actively Employed, Name of Present Employer:	
Marital Status (Check One)	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		

BENEFICIARY DESIGNATION FORM

I designate the following person(s) as my beneficiary (ies) to receive benefits which may be payable from the MEBA Medical and Benefits Plan upon my death. I revoke all previous beneficiary designations and make the designation of beneficiary(ies) shown below with respect to benefits provided now or at any time in the future under the above Plan, still reserving to myself the privilege of making other and future changes subject to the Plan provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise provided herein (total must equal 100%). If no beneficiary survives me, settlement will be made in accordance with the provisions of the Plan. **NOTE: Co-beneficiaries receive proceeds in equal shares, unless otherwise indicated. Contingent Beneficiary is the person who will receive the proceeds if the primary beneficiary should predecease the person whose life is insured.**

Name: **Check One:** ○ Beneficiary ***or*** ○ Co-Beneficiary			
	Last Name First Name Initial Relationship		
Address of Beneficiary			
	Number & Street City State Zip		
Beneficiary's Social Security Number		Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female

Revised 12/2010

CO-BENEFICIARY (IES) OR CONTINGENT BENEFICIARY (IES)

Name: **Check One:** ○ Beneficiary ***or*** ○ Co-Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	
Name: **Check One:** ○ Co-Beneficiary ***or*** ○ Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

Name: **Check One:** ○ Co-Beneficiary ***or*** ○ Contingent Beneficiary				
	Last Name	First Name	Initial	Relationship
Address of Beneficiary				
	Number & Street	City	State	Zip
Beneficiary's Social Security Number			Percent (%) of Benefit:	_____%
Date of Birth (mm/dd/yyyy)		Sex (Check One)	○ Male ○ Female	

(Attach a separate sheet to your Permanent Data Form if you have more than two Co-Beneficiaries)

Signature of Employee		Date	

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT
FORM WILL BE RETURNED IF NOT SIGNED AND DATED.

MEBA BENEFIT PLANS

MEBA MEDICAL & BENEFITS PLAN
MEBA PENSION TRUST
MEBA TRAINING PLAN
MEBA VACATION PLAN

1007 EASTERN AVENUE, BALTIMORE, MARYLAND 21202-4345 • (410) 547-9111

AUTHORIZATION FOR DIRECT DEPOSIT OF PENSION BENEFITS

I, the Participant, authorize the MEBA Pension Plan and the designated Bank to automatically deposit my Pension benefit to my bank account each month. If funds to which I am not entitled are deposited to my account, I authorize the MEBA Pension Plan to direct the Bank to return said funds. This authority will remain in effect until I have cancelled it in writing.

I understand that the MEBA Pension Plan will require periodic verification of my signature. I will cooperate fully in meeting these requirements.

If this is a joint or tenant in common account with any other person including but not limited to my spouse, the Participant and any other such signatory agree to hold harmless, release, waive and forever discharge the MEBA Pension Plan with respect to any use, alienation or hypothecation by such other person, of funds deposited by the MEBA Pension Plan. The Participant and any other such signatory further agree and recognize that the direct deposit of the Participant's Pension Benefit to the designated account confers no rights or privileges either contractual or by operation of law to any joint account holder or tenant in common in such account and such other signatory further agrees to the immediate notification to the MEBA Pension Plan and termination of such direct deposit on the death of the Participant.

☐ **PLEASE CHECK HERE IF THIS IS AN ADDRESS CHANGE FOR PENSION PURPOSES**

Your Name: _____
(Please Print)

Your Address: _____ _____ _____ _____
Number and Street | City | State | Zip

Your Social Security Number: _____

Your Telephone Number: _____ _____
(Area Code)

Your Signature: _____ Date: _____

Joint Signature Name: _____ Date: _____
(If Applicable)

Joint Signature: _____ Date: _____
(If Applicable)

PLEASE SEE OTHER SIDE

THE FOLLOWING SECTION MUST BE COMPLETED BY YOUR BANK

The Bank hereby agrees to accept the direct deposit of the Participant's monthly Pension checks under the terms and conditions outlined on the front of this form. The Bank further certifies that the signature of the Participant and the joint account holder or tenant in common (if applicable) appearing on the front of this form is/are the true signature(s) of the pensioner(s) named.

Bank Name: _____
(Please Print)

Bank Address: _____ _____ _____ _____
Number and Street City State Zip

Account Name: _____

Account Number: _____

Type of Account: _____

Transit Routing Number: _____

Bank Officer: _____
(Please Print)

Title: _____

Signature: _____

Date: _____ Telephone: _____

Please return this form and direct any inquiries to:

DIRECT DEPOSIT PROGRAM
MEBA PENSION PLAN
1007 EASTERN AVENUE
BALTIMORE, MD 21202