

## INQUIRY REGARDING PENSION CREDITS

TO: UFCW — Employers Benefit Funds  
 P.O. Box 8085 Walnut Creek, California 94596-8085  
 Phone # (800) 552-2400

Please check:  
 Food/Meat Industry Employment  
 Drug Store Employment  
 Specialty Stores Employment

EMPLOYEE to complete / Print or Type

NAME	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	UFCW Union #
STREET ADDRESS	SOC. SEC. NUMBER	DATE OF BIRTH
CITY STATE ZIP	DATE FIRST EMPLOYED IN INDUSTRY	
TELEPHONE (DAYS)	DATE LAST EMPLOYED IF NOT CURRENT	
ANY OTHER SURNAME – e.g., maiden	I AM PLANNING TO RETIRE SOON <input type="checkbox"/> Yes <input type="checkbox"/> No	
ARE YOU WORKING AT PRESENT IN CALIFORNIA UNDER A UFCW CONTRACT? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO, PLEASE ADVISE YOUR CURRENT WORK STATUS	

Complete your employment history below beginning with the store or company where you are now employed and list all jobs back to the first one, showing the type of work performed.

	NAME OF STORE/COMPANY	CITY	CLASSIFICATION (Clerk, Meatcutter, Pharmacist, Manager, etc.)	DATES OF EMPLOYMENT			
				From		To	
				Month	Year	Month	Year
1	Present Employer					Present	
2							
3							
4							
5							
6							
7							
8							

Please complete the section below for all periods of your work history during which you were not in a union position in the industry.

REASONS FOR BREAK IN EMPLOYMENT	DATES OF BREAKS IN EMPLOYMENT			
	From		To	
	Month	Year	Month	Year
Military Service (ATTACH DD-214's)				
Illness or injury (PROVIDE DOCTOR'S NAME AND COMPLETE MAILING ADDRESS ON BACK OF FORM)				
Exempt Employment (EMPLOYER/POSITION/LOCATION)				
UFCW employment outside Northern California (EMPLOYER AND LOCATION)				
Worked in other industry or trade (EMPLOYER AND TYPE OF WORK)				
Self-Employment (TYPE OF STORE/INDUSTRY/LOCATION)				
Other Causes (STATE BRIEFLY AND GIVE DATES):				

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning my history. A copy or photocopy of this authorization shall be as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS IS NOT AN APPLICATION FOR RETIREMENT BENEFITS.**  
 If you wish to apply for Pension Benefits, contact your Union Local or the Fund Office.

**FOR PERIODS OF DISABILITY PLEASE PROVIDE COMPLETE  
PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER BELOW**

<u>Period Disabled</u>	Physician's Name: _____
_____ thru _____	Address: _____
mm/dd/yy mm/dd/yy	City/St/Zip: _____
	Telephone Number: _____
Did you receive Worker's Compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to either question, and you were employed in the food or meat industry, please attach copies of benefit payments. <i>(If you do not have all copies, please contact State Disability for Form DIS0306 or your Workers' Compensation carrier to obtain a print-out of their payment records.)</i>	

<u>Period Disabled</u>	Physician's Name: _____
_____ thru _____	Address: _____
mm/dd/yy mm/dd/yy	City/St/Zip: _____
	Telephone Number: _____
Did you receive Worker's Compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to either question, and you were employed in the food or meat industry, please attach copies of benefit payments.	

<u>Period Disabled</u>	Physician's Name: _____
_____ thru _____	Address: _____
mm/dd/yy mm/dd/yy	City/St/Zip: _____
	Telephone Number: _____
Did you receive Worker's Compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to either question, and you were employed in the food or meat industry, please attach copies of benefit payments.	