AIRCONDITIONING & REFRIGERATION INDUSTRY HEALTH AND WELFARE TRUST FUND
APPLICATION FOR DEATH BENEFITS – DB05

Instructions: Use this form if you are a beneficiary and wish to apply for a death benefit. Please note that the signature on this form must be notarized or witnessed by a Trust Employee. Return this form with a copy of the death certificate to the Trust Office at:

Airconditioning & Refrigeration Trust, 3500 W. Orangewood Avenue, Orange, CA 92868

Questions: If you would like more information about death benefits, please contact the Trust Office at (714) 917-6100, Monday through Friday, 8:00 AM to 4:00 PM.

DECEDENT'S INFORMATION (Please type or print in blue or black ink.)

Name: _____SSN:_____

If accidental death, please check this box ☐

Claimant's relationship to deceased

☐ Parent ☐ Child ☐ Spouse ☐ Beneficiary

Date of Death: _____ ***Original certified copy of Death Certificate must be submitted with application***

AUTHORIZATION*:* I hereby make application to the Airconditioning and Refrigeration Industry Health and Welfare Trust Fund for the death benefit payable on behalf of the above named plan participant. I understand that this benefit is **taxable income** and that I will receive a 1099-R Form for the amount of the benefit which will be filed with the Internal Revenue Service at the end of the calendar year in which I receive this benefit.

☐ Do **not** withhold federal taxes

☐ Withhold federal taxes of _____%

CALIFORNIA RESIDENTS: *California state taxes will be automatically withheld at the rate of 10% of the above federal withholding*

Print Name of Claimant: _____SSN:_____

Address:_____Phone:_____

STATEMENT OF RESIDENCY

Country of Citizenship and Residency:

☐ I am a citizen or resident alien of the United States

☐ I am **not** a citizen or resident alien of the United States. I am a citizen of _____(name of country) and a resident of _____(name of country)

State of United States Residency:

☐ I am a resident of California (state taxes may be withheld)

☐ I am **not** a resident of California

Signature of Claimant: _____Date:_____

WITNESS: Trust Office Personnel _____ Date: _____OR ☐ Notarial Jurat Attached

TRUST OFFICE APPROVAL: The participant is eligible for the distribution under the terms of the Plan.

Amount Authorized: $_____

☐ Active Participant ☐ Active Dependent ☐ Retiree

Authorized Approval Signature: _____ Date: _____