



CERTIFICATION OF TERMINATION OF COVERED EMPLOYMENT AND TRANSITION TO NON-COVERED EMPLOYMENT

Part 1 must be completed by the Participant.

Part 2 must be completed by your Employer.

PART 1—PARTICIPANT CERTIFICATION

Participant Name _____
Social Security Number (only last 4 digits required)

Phone Number _____
Email Address

I understand that, to qualify for a distribution due to a transition from Covered Employment (as a bargaining unit member) to non-Covered Employment, I **MUST** meet the following criteria:

- A. I am age 59½ or older (only applies to In-Service Distribution);
- B. I have not been working in Covered Employment for at least one year; and
- C. I have worked in a non-Covered Employment position with a Signatory Employer for at least one year and continue to work in that position.

I certify that I satisfy these requirements and agree to inform the Fund Office immediately if, before my benefit is paid, B or C no longer applies.

X _____
Signature _____
Date

PART 2—EMPLOYER CERTIFICATION

I certify that the above-identified employee has been employed by my company for at least one year in a position that is not covered by a District Council 16 collective bargaining agreement and that this individual continues to be employed in this position as of this date.

X _____
Signature _____
Date

Employer Name: _____