

STAFF PENSIONERS

TO BE COMPLETED AND SIGNED BY PENSIONER OR PERSON DESIGNATED
TO REPRESENT THE PENSIONER:

Pensioner's name: _____ Pensioner's IDN: _____

This question relates to your current employment status

___ I am employed in employment covered by the Staff Plan (as described in Plan Section H1.09 attached).

___ I am not employed in employment covered by the Staff Plan (as described in Section H1.09 attached).

___ The Pensioner is deceased (must provide a copy of the death certificate).

If Pensioner is Employed, Please Complete the Following:

Employer's Name: _____

Employer's Address: _____

Type of Business: _____

Date of Employment Began: _____ Ended: _____

Number of Hours Employed Per Month: _____

Explanation of work Performed for Employer:

By signing below, I hereby authorize my employer listed above and on the attachment to this document, if applicable, and any other employer that MEBA Pension Trust – Defined Benefit Plan asks to provide information regarding my employment, to provide the information requested.

I understand that providing false information to the Plan to receive benefits is a federal crime under 18 U.S.C. § 664, which provides that "any person who embezzles, steals, or unlawfully and willfully abstracts or converts to his own use or to the use of another, any of the moneys, funds, securities, premiums, credits, property or other assets of any employee welfare benefit plan or employee pension benefit plan, or of any fund connected therewith, shall be fined under this title, or imprisoned not more than five years, or both."

Participant's Signature: _____ Date: _____

If someone other than the Participant is executing this form, then a Power of Attorney must be attached:

Name of Person Completing this Form: _____

Relationship to Participant: _____

Signature: _____

Date: _____

___ Power of Attorney Attached