Milk Drivers and Dairy Employees Local Union No. 246
of Washington, D.C.
Pension Fund

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Landover, Maryland 20785-2361
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RETIREMENT DECLARATION

Upon retiring on a pension from the Plan for the Milk Drivers & Dairy Employees Fund, I declare that I will be bound by the rules and regulations of the Pension Plan as they now exist or are hereafter amended and that:

1. I understand that I cannot work more than 40 hours in employment which is located in the District of Columbia, Virginia or Maryland, in any industry of the type covered by the Plan, and in the same trade or craft as my previous covered employment.

2. I understand that if I enter such employment my Pension Benefits will be suspended for each month in which I work 40 or more hours.

3. I understand I must notify the Trustees in writing when I start employment and when I stop on a form provided by the Trustees.

4. I understand that my Pension Benefits shall resume on the first day of the third calendar month after I have stopped working in Prohibited Employment, provided I have notified the Pension Fund in writing that I have stopped.

5. I understand that if the Pension fund paid my Pension for any month in which I was working in Prohibited Employment, the Trustees may deduct the amount improperly paid from resumed payments; 25% will be deducted from each resumed payment.

6. I understand I must certify annually in writing that I have not worked in employment requiring my pension to be suspended or I have notified the Fund of such work.

7. If I receive a disability pension from the Fund, I understand I must provide to the Trustees annually, a copy of my Social Security disability benefit check.

8. I understand that if I obtain employment while on a disability pension and am paid $5,000 per year or more, my disability pension will cease thirty (30) days after I start such employment.

9. I understand that if later I earn less than $5,000 per year, my disability pension will be reinstated in accordance with regulations prescribed by the Trustees.

10. I understand and I cannot receive a disability pension during any period I am receiving Worker's Compensation.

11. I understand that I must personally endorse each check.

12. Date I stopped working or plan to stop work:_____

RETIREE'S SIGNATURE_____DATE_____

PRINT NAME_____SOCIAL SECURITY NUMBER_____