IAM National Pension Fund
99 M Street S.E., Suite 600
Washington, DC 20003 -3799
Fax 202-857-3713 • Phone 800-424-9608 • www.iamnpf.org

Re: Incapacitated Pensioner Forms

Award No: _____

Pensioner: _____

We have received notification that the above-named pensioner is unable to sign his/her checks. As a result, the enclosed Incapacitation Form(s) must be completed.

If you have court-appointed conservator/guardianship papers, you may submit them instead of the enclosed forms.

If you do not have the above documents, please do the following:

The enclosed Physician's Statement of Incapacitated Benefit Recipient (white form) should be completed by the Pensioner's physician. ***For mental incapacitation, the physician must indicate the onset date (month/year) of the incapacitation on the form.*** Once the physician returns the form, you may forward it to the Fund Office with a valid Power of Attorney.

If you do not have a valid Power of Attorney, send one of the following forms with the Physician Statement:

(a) If the pensioner is **PHYSICALLY** incapacitated but mentally competent to handle his/her affairs, please have the pink form (Statement of Incapacitated Benefit Recipient) completed and signed before a Notary Public.

(b) If the physician states that the pensioner is **MENTALLY** incompetent to conduct his/her business affairs please have the yellow form (Statement of Incapacitated Pensioner's Relative Accepting Benefits on Pensioner's behalf) completed and signed before a Notary Public.

If no response is received within thirty (30) days of the date of this letter, all future checks will be held pending receipt of the forms or court papers.

Should you have any questions, please do not hesitate to contact us at 1-800-424-9608 Ext 277.

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PHYSICIAN STATEMENT OF INCAPACITATED BENEFIT RECIPIENT
(Form must be completed in its entirety.)

I certify that _____ (Benefit Recipient) was under my professional and/or medical care from _____, 20____ to _____, 20 ____, and upon examination on _____, 20 _____, I found him/her:

( ) to be physically incapacitated but mentally competent to handle his/her affairs.

( ) to be mentally incompetent to conduct his/her business affairs, commencing
(month/year)

*Nature of incapacitation _____

_____

Condition appears to be ( ) permanent ( ) temporary

_____
Signature of Physician

_____
Print Name of Physician

Address: _____

_____

Area Code/Phone number: _____

(*Nature of incapacitation **MUST BE COMPLETED**)

"Pink Form"

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STATEMENT OF INCAPACITATED BENEFIT RECIPIENT (To be used by family member - All others must submit Court Appointed Conservator/Guardianship Papers or a Durable Power of Attorney.)

This is to affirm that as of this date I am physically unable to endorse my monthly pension check from the IAM National Pension Fund and that I hereby authorize _____, _____
Print Name, Relationship
to endorse these checks on my behalf for as long as my disability continues or until I notify the Pension Fund Office otherwise.

1. _____ _____
Signature of Witness — Signature (or mark*) of Pensioner

2. _____ Date Signed _____
Signature of Witness — ***A mark can be accepted as long as it is notarized.**

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STATEMENT OF PERSON AUTHORIZED BY PENSIONER TO ENDORSE CHECKS ON HIS/HER BEHALF

I accept the above authorization and understand that such authority is valid only for as long as the Pensioner is living and is incapacitated. Upon his recovery, the Fund Office will be notified promptly. In the event of his/her death, I will notify the Fund Office and immediately return any checks subsequently issued.

_____ Address: _____
Signature of person authorized to endorse checks

_____

_____ Date Signed _____
Print Name

Notary's Certification

STATE OF)
) ss.
COUNTY OF)

On the _____ before me _____
Date **Name and Title of the Officer**
personally appeared _____ known to me (or
Name of Person Authorized to Endorse Checks
proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person executed the instrument.

WITNESS my hand and official seal.
My commission expires on _____

Signature _____ (Seal)

"Yellow Form"

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STATEMENT OF INCAPACITATED PENSIONER'S RELATIVE ACCEPTING BENEFITS ON PENSIONER'S BEHALF

I acknowledge that the Pensioner/Applicant identified below is living and is mentally incapacitated as indicated on the Physician's Statement previously submitted. I further agree to receive pension benefits from the Fund on behalf of the Pensioner and use these solely in the Pensioner's interest. In the event of the Pensioner's recovery, the Fund Office will be notified promptly. In the event of his death, I will notify the Fund Office and immediately return any checks subsequently issued.

Name of Pensioner/Applicant _____

_____ _____
Name of Person Authorized to Receive Payments Relationship to Pensioner/Applicant

Your Address _____
_____

_____ _____
Signature of Person Authorized to Receive Payments Date signed

Notary's Certification

STATE OF)
) ss.
COUNTY OF)

On the _____ before me _____
(Date) **(Name and Title of the Officer)**
personally appeared _____
(**Name of Person Authorized to Receive Payments)**

known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person executed the instrument.

WITNESS my hand and official seal.

My commission expires on _____

Signature_____ (Seal)