



## Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan Application for Severance Benefit

To be eligible for the Severance Benefit, employer hours must not have been submitted on participant’s behalf in any of the last four (4) consecutive work months to any of the following plans: the Defined Contribution Plan, the Health Care Plan, and the Electrical Workers Local No. 292 Pension Plan or working in the Disqualifying Employment. Disqualifying Employment for purposes of subsection (A) means employment or self-employment that is (i) in an industry covered by the Plan when the participant requests benefits, (ii) in a geographic area covered by the Plan when the participant benefits, and (iii) in an occupation in which Plan Participants work (including, but not limited to electrical positions and Alumni Employee positions)

1. The term “industry covered by the Plan” means the electrical industry and any of the industry in which employees covered by this Plan were employed.
2. The geographic area covered by the Plan is the State of Minnesota plus the remainder of any Standard of Metropolitan Statistical Area which falls partially within any of those states. The geographic area may be changed by the negotiation in future Contribution Agreements, which require Employer Contributions to be made to the Plan.

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Have you been employed in the last 5 months? Yes  No

**If Yes, please complete the employment information on the reverse side of this application.**

In accordance with the provisions of the Electricians’ Income Security Trust Agreement, I hereby apply for the Electrical Workers Local No. 292 Supplemental Unemployment Benefit Plan Severance Benefit. I hereby certify that the statements on this form are true and complete to the best of my knowledge and belief.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**20% Federal taxes and 5% State taxes apply to all applicants**

Completed Applications can be returned to:  
IBEW 292 Benefits Office  
6700 West Broadway Avenue, Suite B  
Brooklyn Park, MN 55428  
763-493-8830 Fax 763-416-6196  
subfund@ibew292benefits.org

*Office Use Only*

Date \_\_\_\_\_

Approved

Denied

Authorized Signature \_\_\_\_\_

# Employment History

Please include all jobs worked in the last four years. If additional room is required please attach a second form.

Company Name \_\_\_\_\_ Job Title \_\_\_\_\_

Company Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Job Description and Duties \_\_\_\_\_

Start Date \_\_\_\_\_ Term Date \_\_\_\_\_

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Company Name \_\_\_\_\_ Job Title \_\_\_\_\_

Company Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Job Description and Duties \_\_\_\_\_

Start Date \_\_\_\_\_ Term Date \_\_\_\_\_

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Company Name \_\_\_\_\_ Job Title \_\_\_\_\_

Company Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Job Description and Duties \_\_\_\_\_

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Company Name \_\_\_\_\_ Job Title \_\_\_\_\_

Company Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Job Description and Duties \_\_\_\_\_

Start Date \_\_\_\_\_ Term Date \_\_\_\_\_