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

I, ______________________________ (Name of Agent), certify under penalty of perjury that ______________________________ (Name of Participant or Beneficiary) granted me authority as an agent or successor agent in a Power of Attorney dated _________________________ (MM/DD/YYYY).

I further certify that to my knowledge:

1. The Participant or Beneficiary is alive and has not revoked the Power of Attorney or my authority to act under the Power of Attorney, and the Power of Attorney and my authority to act under the Power of Attorney has not terminated;

2. There are no proceedings pending to revoke my authority under the Power of Attorney or to appoint another person as guardian or conservator for the Participant or Beneficiary;

3. The Power of Attorney has come into effect because the Participant or Beneficiary is incapacitated; and

4. A Physician's Statement is attached to this statement.

I agree to manage the Participant or Beneficiary's pension benefits received under the IAM National Pension Fund ("Fund"). I will exercise my authority solely in the Participant or Beneficiary's interest.

I agree not to exercise any powers granted by the Power of Attorney if I attain knowledge that it has been revoked, partially or completely terminated, suspended, or is no longer valid because of the death of the Participant or Beneficiary. In the event of the Participant or Beneficiary's death, I will notify the Fund and immediately return any checks subsequently issued.

SIGNATURE AND ACKNOWLEDGEMENT

_______________________________ *(Agent's signature)*

_______________________________ *(Date signed)*

_______________________________ *(Agent's name printed)*

_______________________________ *(Relationship to Participant or Beneficiary)*

_______________________________ *(Agent's address)*

_______________________________ *(Agent's telephone number)*

NOTARY'S CERTIFICATION

STATE OF)
) ss.
COUNTY OF)

Subscribed and sworn (or affirmed) before me on this ________ day of ________________, _______,

at ________________________________, _______________________.
(City) *(State)*

[SEAL]

____
(Signature of officer)

____
(Title)

Commission expires __________________________
(If by a Notary Public, the date of expiration of their Commission should be shown)

PHYSICIAN'S STATEMENT

Note to Healthcare Provider: A completed physician's statement is required to evaluate an agent's request to manage a participant or beneficiary's pension account. A physician, psychiatrist, psychologist, physician assistant, or registered nurse must complete and sign this form. Please answer all the following questions on this form or provide the following information on your letterhead.

Definition of Incapacity: For the purposes of this form, "Incapacitated" means "the inability of an individual to manage his or her property or financial affairs due to a medical condition impairing their cognitive functions, e.g., dementia, Alzheimer's, etc."

1. I certify that ________________________ ("Patient") was under my professional and/or medical care from ______________________ (MM/DD/YYYY) to ______________________ (MM/DD/YYYY).

2. In my professional opinion, within a reasonable degree of medical certainty, the Patient:

   ☐ has the capacity to make responsible decisions concerning the Patient's own financial affairs.
   ☐ is incapacitated according to the definition given above, commencing ___________ (MM/YYYY).

3. Upon examination on ___________________________ (MM/DD/YYYY), I determined that the medical diagnoses affecting the Patient's capacity to manage their own financial affairs are as follows:

   ____

   ____

   ____

   The condition(s) impacting the Patient's capacity are:

   ☐ permanent ☐ temporary ☐ indeterminable (please explain below).

   ____

I affirm upon personal knowledge that the contents of this document are true.

Print Name of Physician/Psychiatrist/Psychologist/PA/RN		Signature	License Number	
Name of Facility (if applicable)		Name of Supervising Physician (if PA)		
Telephone Number	Address			State