NFLPA Response to Questions of October 12, 2007

EXHIBIT

F

REVISED 9/12/06

Bert Bell/Pete Rozelle NFL Player Retirement Plan

Application for Disability Benefits

Instructions

To apply for disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan"), you must complete this application and return it to the Plan Office with all required information. The Plan Office will tell you if further information is required. Your application will not be considered complete until the Plan Office receives this application with all required information.

In general, the Plan provides total and permanent disability ("T&P") benefits to eligible players who are substantially unable to work, and line-of-duty disability ("LOD") benefits to eligible players who suffer a "substantial disablement." The end of this form contains further information about these benefits.

Player Information

Name_____

Date of Birth (attach birth certificate)_____ Social Security No._____

Address (No., Street)_____ Home Phone_____

City, State, Zip_____ Office Phone_____

Benefits Requested

This is an application for (please check one):

( ) Only line-of-duty disability ("LOD") benefits (complete LOD section below)
( ) Only total and permanent disability ("T&P") benefits (complete T&P section below)
( ) Both LOD and T&P benefits (complete both LOD and T&P sections below)

Line-of-Duty ("LOD") Benefits

To be eligible for LOD benefits, the Plan Office must receive your application within 48 months after you cease to be an Active Player, as defined by the Plan. This 48-month period may be extended if you have been physically or mentally incapacitated in a manner that substantially interfered with your ability to file this claim. If you seek such an exception, or wish to describe when you ceased to be an Active Player, please do so below or on an additional sheet:

_____
_____
_____
_____

Describe the condition or conditions you have that you believe qualify you for LOD benefits:

1. _____
2. _____
3. _____
4. _____

(Attach additional sheet if necessary)

Do you wish to provide additional information in support of your application for LOD benefits?

( ) Yes ( ) No

If you checked "Yes," describe that information and attach all documents to this application:

_____
_____
_____

Total and Permanent Disability ("T&P") Benefits

A. Employment Information and Effective Date

1. Are you currently employed? ( ) Yes ( ) No

   If you checked "Yes," please complete the following:

   Employer _____ Job Title _____
   Employer's address _____
   Name of immediate supervisor _____ Phone number of supervisor _____

   If you checked "No," please complete the following:

   Last date of employment _____ Employer _____ Job Title _____
   Employer's address _____
   Name and phone number of immediate supervisor _____
   Reason for leaving _____
   Job description and responsibilities _____

2. Do you seek retroactive T&P benefits (benefits for periods before you are examined by a physician selected by the Plan)? ( ) Yes ( ) No

   If you checked "No," skip to Section B "Disabilities and Cause." If you checked "Yes," provide the earliest date you believe you became unable to work and complete the rest of this Section A: _____

   The date you indicated on the prior line is your "Requested Effective Date." Describe why you chose this date:
   _____
   _____
   _____

3. The Plan does not provide T&P benefits for periods more than 42 months before your application is received by the Plan Office, unless you are found to have been mentally or physically incapacitated in a manner that substantially interfered with the filing of this application. If you seek such an exception to this 42-month rule, list below or on an additional sheet all reasons for which you claim an exception:
   _____
   _____
   _____

4. Employment History

   Please complete the following for each job that you have held from your Requested Effective Date to the present:

   Last Employer _____ Job Title _____ Dates of employment _____
   Job Description/Responsibilities _____
   Employer's address _____
   Name of immediate supervisor _____ Phone number of supervisor _____
   Reason for leaving (i.e., why you quit or were fired) _____

   Prior Employer _____ Job Title _____ Dates of employment _____
   Job Description/Responsibilities _____
   Employer's address _____
   Name of immediate supervisor _____ Phone number of supervisor _____
   Reason for leaving (i.e., why you quit or were fired) _____

Prior Employer _____ Job Title _____Dates of employment _____
Job Description/Responsibilities _____
Employer's address _____
Name of immediate supervisor _____ Phone number of supervisor _____
Reason for leaving (i.e., why you quit or were fired)_____

Prior Employer _____ Job Title _____Dates of employment _____
Job Description/Responsibilities _____
Employer's address _____
Name of immediate supervisor _____ Phone number of supervisor _____
Reason for leaving (i.e., why you quit or were fired)_____
(Attach additional sheets if necessary)

5. Tax Returns

You are requesting a retroactive effective date for total and permanent disability benefits. Therefore, enclose with this application complete copies of all federal income tax returns for the year before your Requested Effective Date through the present. These complete copies must include all schedules and related forms, such as W-2 forms. If you do not have copies of any of these forms or if you did not file a federal tax return for any of these years, you must request copies of your tax returns or verification of non-filing from the IRS using Form 4506 (copy attached). Since you are requesting retroactive total and permanent disability benefits, your application will not be complete and will not be considered by the Plan until the Plan Office receives all of these federal income tax returns. Please note that tax returns for this and later periods may be requested periodically by the Retirement Board.

6. Social Security Earnings Statement

If your Requested Effective Date is more than one year prior to the date of this application, you must enclose (or forward later to the Plan Office) a current copy of your detailed Social Security earnings history. Use Form SSA-7050 (copy attached) to request this detailed earnings history.

7. Medical and Hospital Records

Enclose, with this application, complete copies of all medical and hospital records for all years for which benefits are claimed. You may get a copy of these records by asking your providers (that is, physicians, hospitals, etc. that have treated you) for your records.

B. Disabilities and Cause

1. Describe all of the conditions that you believe make you unable to work. Please indicate for each:

   A. The type or types of doctors you have seen because of this condition. (For example, orthopedist, cardiologist, neurologist, psychiatrist, internist, oncologist, endocrinologist, ear nose and throat, opthalmologist, gastroenterologist, urologist, dermatologist.) Write "None" if you have not seen a doctor for this condition.

   B. Whether you believe this condition resulted from NFL Football activity, from service in the military of any country, or from other causes.

   C. Describe this condition, and explain how it prevents you from working. If you believe this condition resulted from NFL Football activity, also describe how NFL activity caused this condition.

   You may attach additional sheets if you require more space.

Condition 1:

Physician Types: _____

Cause of Condition ( ) NFL Football ( ) Military Service ( ) Other

Description: _____

_____

_____

_____

_____

Condition 2:

Physician Types: _____

Cause of Condition ( ) NFL Football ( ) Military Service ( ) Other

Description: _____

_____

_____

_____

_____

Condition 3:

Physician Types: _____

Cause of Condition ( ) NFL Football ( ) Military Service ( ) Other

Description: _____

_____

_____

_____

_____

Condition 4:

Physician Types: _____

Cause of Condition ( ) NFL Football ( ) Military Service ( ) Other

Description: _____

_____

_____

_____

_____

(Attach additional sheet if necessary.)

2. Describe all accidents, injuries, or illnesses that did not result from NFL Football (for example, auto accidents) and that may have caused or contributed in any way to any of the above conditions:

_____

_____

3. Please note that special rules apply where a condition relates to alcohol or substance abuse, or to psychiatric problems. In general, if such conditions are the cause of your inability to work, they will automatically be considered to not result from NFL Football activities. Certain exceptions apply, as described at the end of this form. If you believe you qualify for one of these exceptions, please describe and enclose all supporting documentation.

____
____
____

C. Attending Physicians

Please list the names of your treating physicians for each of the conditions described in Part B above. You should not list the names of your team physicians or physicians that the Plan has referred you to. You may attach additional sheets if you require more space.

Name of Physician ____________________ Condition for which seen ____________
Dates of Treatment ______________ Approximate number or frequency of office visits ________
Physician's Address and Phone Number ______________________________
____
____

Name of Physician ____________________ Condition for which seen ____________
Dates of Treatment ______________ Approximate number or frequency of office visits ________
Physician's Address and Phone Number ______________________________
____
____

Name of Physician ____________________ Condition for which seen ____________
Dates of Treatment ______________ Approximate number or frequency of office visits ________
Physician's Address and Phone Number ______________________________
____
____

Name of Physician ____________________ Condition for which seen ____________
Dates of Treatment ______________ Approximate number or frequency of office visits ________
Physician's Address and Phone Number ______________________________
____
____

Name of Physician ____________________ Condition for which seen ____________
Dates of Treatment ______________ Approximate number or frequency of office visits ________
Physician's Address and Phone Number ______________________________
____
____

Name of Physician ____________________ Condition for which seen ____________
Dates of Treatment ______________ Approximate number or frequency of office visits ________
Physician's Address and Phone Number ______________________________
____
____

D. Other Information

Do you wish to provide additional information in support of your application for T&P benefits? You are encouraged to provide any information you believe will be helpful to the consideration of your application.

( ) Yes ( ) No

If you checked "Yes," describe that information and attach all documents to this application:

____
____

Worker's Compensation/Social Security Disability Information

Have you ever applied for Workers' Compensation? o Yes o No

What was the result of your application?
o Benefits Awarded
o Benefits Denied
o Application Pending
Attach copy of decision, if benefits were awarded or denied.

If you were awarded Workers' Compensation benefits, how much is the benefit and in what form is it paid_____
_____
_____

Workers' Compensation Claim No.
_____State___

Have you ever applied for Social Security Disability Benefits?
o Yes o No

If you have not applied for Social Security Disability Benefits, you may wish to consider doing so.

What was the result of your application?
o Benefits Awarded
o Benefits Denied
o Application Pending
Attach copy of decision, if benefits were awarded or denied.

If you were awarded Social Security Disability Benefits, how much is the monthly benefit?_____
_____
_____

Social Security Claim No._____
_____
_____
_____

Have you ever applied for disability benefits from your current employer or from any prior employer?
o Yes o No

What was the result of your application?
o Benefits Awarded
o Benefits Denied
o Application Pending
Attach copy of decision, if benefits were awarded or denied.

If you have received or have ever been awarded disability benefits by any employer, how much is or was the benefit and in what form is or was it paid?_____
_____
_____
_____

I hereby apply for disability benefits from the Plan. I certify that all the information provided on or with this application is, to the best of my knowledge, true, correct, and complete. I certify that any and all documents or information attached to or enclosed with this application are, to the best of my knowledge, true, correct, and complete. I recognize that I may be subject to loss of benefits and to other penalties and sanctions under law if I have made any false or misleading statements or omissions.

Player's Signature _____**Date**_____

Authorization for Use or Disclosure of Individually Identifiable Health Information

In connection with your application for disability benefits, you may submit, or have submitted on your behalf, individually identifiable health information, including your disability application, medical records, and physician reports. You also may be referred to Plan neutral physicians or Medical Advisory Physicians for medical examinations, and these physicians may submit health information to the Plan on your behalf.

Please sign below to indicate your authorization for the Plan, its agents, and other individuals associated with the Plan to use or disclose your health information for Plan purposes.

I hereby authorize the Bert Bell/Pete Rozelle NFL Player Retirement Plan to use or disclose all individually identifiable health information submitted to the Plan on my behalf, or created in connection with my application for disability benefits, to all individuals as needed for Plan purposes.

Player's Signature _____**Date**_____

Mail Completed Form to: **Bert Bell/Pete Rozelle NFL Player Retirement Plan**
200 St. Paul Place, Suite 2420
Baltimore, Maryland 21202-2040
(410) 685-5069 (800) 638-3186

GENERAL INFORMATION

For your convenience, we have paraphrased portions of the Summary Plan Description for the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan"). In the event of a conflict between these descriptions and the Plan document, the Plan document will control.

When Are You Eligible for Disability Benefits?

The Plan provides two kinds of disability benefits – total and permanent disability benefits and line-of-duty disability benefits.

To receive either type of disability benefit, you must file an Application for Disability Benefits with the Plan Office. This application is available from the Plan Office.

For line-of-duty disability benefits, you must submit the application within forty-eight (48) months after you cease to be an *Active Player*. This application period will be extended for any period of time that the Disability Initial Claims Committee or the Retirement Board finds you to have been physically or mentally incapacitated in a manner that substantially interferes with the filing of your claim.

Total and permanent disability applications are subject to the following rules:

- In general, you will not receive total and permanent disability benefits with respect to any month that precedes by more than 42 months the date the Plan first receives a written application or similar letter requesting such benefit.

- You are not eligible for disability benefits for any past or future period if you first file a claim for such benefits after the date that you begin to receive a monthly retirement benefit.

- If your application for total and permanent disability benefits has been denied and is not subject to further review, you cannot file another application for total and permanent disability benefits for twelve months after the final denial. This twelve-month rule may be waived if you become totally and permanently disabled because of a new injury or condition.

Total and Permanent Disability Benefits

If you are totally and permanently disabled, you may be able to receive a total and permanent disability benefit from this Plan if:

- You are an *Active Player* or an inactive *Vested Player*;
- You are not receiving retirement benefits; and
- You have at least one *Credited Season* after 1958.

You are totally and permanently disabled if the Disability Initial Claims Committee or the Retirement Board determines that you are substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit. You will not be considered to be able to engage in any occupation or employment for remuneration or profit merely because you are employed by the NFL or a Club, manage personal or family investments, are employed by or associated with a charitable organization, or are employed out of benevolence. You are not totally and permanently disabled as a result of a disability suffered while in the military service of any country.

For total and permanent disability benefits to be awarded and continued, you may be required to have physical examinations by physicians selected by the Retirement Board. You also may be required to submit to further examinations as necessary for an adequate determination of your condition. You must submit to any required physical examination to be eligible for total and permanent disability benefits.

Special total and permanent disability rules that are more restrictive apply if a previous application by you for total and permanent disability benefits that is related to your present disability was denied before May 6, 1993. Special rules also apply for periods prior to July 1993. For example, prior to July 1993, the standard for total and permanent disability was different, the categories of total and permanent disability were different, and the amount of those benefits was different. Further information about your eligibility for disability benefits under these rules and their applicability to your particular situation may be obtained from the Plan Office.

Line-of-Duty Disability Benefits

You may be entitled to a line-of-duty disability benefit if, as an *Active Player*, you incur a "substantial disablement arising out of NFL football activities." The benefit is payable monthly as of the first day of the month following the date the disability qualifies as a substantial disablement. Payment continues for the duration of your disability, but not for longer than ninety (90) months.

A "substantial disablement" is a permanent disability that satisfies any one of the following criteria.

- For orthopedic impairments, using the American Medical Association *Guides to the Evaluation of Permanent Impairment* (Fifth Edition, Chicago, IL) ("AMA Guides"), is (a) a 38% or greater loss of use of the entire lower extremity; (b) a 23% or greater loss of use of the entire upper extremity; (c) an impairment to the cervical or thoracic spine that results in a 25% or greater whole body impairment; (d) an impairment to the lumbar spine that results in a 20% or greater whole body impairment; or (e) any combination of lower extremity, upper extremity, and spine impairments that results in a 25% or greater whole body impairment.

  In accordance with the AMA Guides, up to three percentage points may be added for excess pain in each category above ((a) through (e)). The range of motion test will not be used to evaluate spine impairments.

- Results in a 50% or greater loss of speech or sight.

- Results in a 55% or greater loss of hearing.

- Is the primary or contributory cause of the surgical removal or major functional impairment of a vital bodily organ or part of the central nervous system.

A line-of-duty disability "arises out of NFL football activities" if it results from any NFL game (including a pre-season or post-season NFL game, or any combination thereof), or out of NFL football activities supervised by a Club, including all required or directed activities. A line-of-duty disability is not caused by NFL football activities if it results from other employment or athletic activity for recreation, or if it would not qualify for benefits but for an injury (or injuries) or illness that arises out of activities other than NFL football activities.

A line-of-duty disability will be considered permanent if it has persisted or is expected to persist for at least 12 months from the date of its occurrence and if you are not an *Active Player*.

Eligibility for line-of-duty disability benefits is determined by the Retirement Board. You must submit to any required physical examination to be eligible for line-of-duty disability benefits. The doctor's report will be filed with the Retirement Board.

What Are Your Total and Permanent Disability Benefits?

Amount

If you are eligible for total and permanent disability benefits, the amount of your monthly benefit is the greater of (a) the sum of your benefit credits for all of your *Credited Seasons*, including, if applicable, the scheduled benefit credit for the *Plan Year* in which the disability occurs, or (b) a minimum benefit that depends on which of the following four categories applies to you:

- **Active Football.** The monthly total and permanent disability benefit will be no less than $4,000 if the disability results from NFL football activities, arises while the *Player* is an *Active Player*, and causes the *Player* to be totally and permanently disabled "shortly after" the disability first arises.

- **Active Nonfootball.** The monthly total and permanent disability benefit will be no less than $4,000 if the disability does not result from NFL football activities, but does arise while the *Player* is an *Active Player*, and does cause the *Player* to be totally and permanently disabled "shortly after" the disability first arises.

- **Football Degenerative.** The monthly total and permanent disability benefit will be no less than $4,000 if the disability(ies) arises out of League football activities, and results in total and permanent disability before 15 years after the end of the Player's last Credited Season.

- **Inactive.** The monthly total and permanent disability benefit will be no less than $1,500 if (1) the total and permanent disability arises from activities other than NFL football activities while the *Player* is an inactive *Vested Player* or (2) the disability arises out of NFL football activities, and results in total and permanent disability 15 or more years after the end of the *Player's* last *Credited Season*. Inactive total and permanent disability benefits will be offset by any disability benefits provided by an employer other than the NFL or a Club, but will not be offset by workers' compensation.

If you qualify for benefits under the "Active Football," "Active Nonfootball" or "Football Degenerative" categories above, you qualify for additional benefits under the NFL Player Supplemental Disability Plan pursuant to the 1993 Collective Bargaining Agreement.

A *Player* who becomes totally and permanently disabled no later than 6 months after a disability first arises will be conclusively deemed to have become totally and permanently disabled "shortly after" the disability first arises, and a *Player* who becomes totally and permanently disabled more than 12 months after a disability first arises will be conclusively deemed not to have become totally and permanently disabled "shortly after" the disability first arises. In cases falling within this 6- to 12-month period, the Disability Initial Claims Committee or the Retirement Board will determine whether the "shortly after" standard is satisfied.

Psychological and Substance Abuse Disabilities

Special rules may apply if your disability is caused by use of, addiction to, or dependence upon (1) a controlled substance, (2) alcohol, or (3) illegal drugs; or if your disability results from a psychological/psychiatric disorder. In general, beginning November 1, 1998, such disabilities are not eligible for benefits under this Plan or the Supplemental Disability Plan in the "Active Football" and "Football Degenerative" categories.

The term "illegal drugs" includes all drugs and substances (other than alcohol and controlled substances) taken in violation of law or NFL policy. The term "controlled substance" is defined by federal law, and includes certain drugs that may be lawfully prescribed by a licensed physician.

Disabilities caused by the use of a controlled substance may qualify for benefits in the "Active Football" or "Football Degenerative" categories if the requirements of either of these categories are otherwise met and (1) such use, addiction, or dependence results from the substantially continuous use of a controlled substance that was prescribed for NFL football activities or for injuries or illness arising out of NFL football activities while you are an *Active Player*, and (2) an application for total and permanent disability benefits is received based on such use of, addition to, or dependence upon a controlled substance no later than eight (8) years after the end of your last *Credited Season*.

A total and permanent disability resulting from a psychological/psychiatric disorder also may qualify for benefits in the "Active Football" or "Football Degenerative" categories if the requirements of either of these categories are otherwise met and the psychological/psychiatric disorder either (1) is caused by or relates to a head injury (or injuries) sustained in NFL football activities; (2) is caused by or relates to the use of a substance prescribed by a licensed physician for an injury (or injuries) or illness arising out of NFL football activities; or (3) is caused by an injury (or injuries) or illness that otherwise qualified you for the "Active Football" category of total and permanent disability benefits.

Please refer to the Plan document if you desire an exact definition of the rules in these areas.

Classification Rules

As long as you remain totally and permanently disabled, you will continue to receive total and permanent disability benefits under the category for which you first qualify, unless you present evidence for reclassification that the Disability Initial Claims Committee or the Retirement Board finds to be clear and convincing.

A *Player's* total and permanent disability benefit will not be retroactively reclassified or increased for periods of time prior to forty-two (42) months before the Plan Office receives a written application or similar letter requesting the reclassification or increase. In determining the appropriate classification under the above four categories of a *Player* who is totally and permanently disabled, it will be conclusively presumed that the *Player* was not totally and permanently disabled for all periods of time prior to forty-two (42) months before the Plan Office receives the written application or similar request that results in the award of a benefit. These forty-two (42) month limitation periods will be extended for any period of time that the Disability Initial Claims Committee or the Retirement Board finds you to have been mentally or physically incapacitated in a manner that substantially interferes with the filing of your claim.

Benefits for Dependents

In addition to your total and permanent disability benefits, $100 a month (or $75 a month if you received an early payment benefit) will be paid to you during your period of disability for each *Dependent* child. Payment will stop when the *Dependent* child has reached age 19 (or age 23 if in college), or is no longer a *Dependent.*

Payment and Duration

The Disability Initial Claims Committee or the Retirement Board may require you to submit to reexaminations, at the expense of the Plan, but not more frequently than once every 6 months. If the Disability Initial Claims Committee or the Retirement Board determines that your disability no longer qualifies as a total and permanent disability, your benefits will stop. If you should then become totally and permanently disabled for a second period of time, the classification and amount of your second benefit will be determined without regard to any prior periods of disability.

If you are incapacitated so as to be unable to manage your financial affairs, the Retirement Board may, in its sole discretion, establish a trust to hold your benefits on your behalf. The Plan may pay all reasonable expenses of the trust and its trustee. More information is available from the Plan Administrative Office.

Your total and permanent disability benefits, including the *Dependent* child benefit, will end when you die. Also, your total and permanent disability benefits will end if the Disability Initial Claims Committee or the Retirement Board determines that you are no longer totally and permanently disabled.

If you or a representative submits false information and, as a result, you receive amounts under the NFL Player Supplemental Disability Plan to which you are not entitled, any further disability benefits payable to you or any beneficiary (including a *Dependent* or alternate payee) under this Plan will be reduced by the amount of the overpayment from the NFL Player Supplemental Disability Plan, plus interest at the rate of 6% per year.

Your Total and Permanent Disability Benefit At Age 55

If you are totally and permanently disabled when you reach your normal retirement date (the first day of the month on or after your 55th birthday), your disability benefits will be converted to a retirement benefit. Your monthly retirement benefit, however, will not be less than the actuarial equivalent of the monthly total and permanent disability benefit that you were receiving when you reached age 55. This retirement benefit will be paid in the form of a Life-Only Pension if you are single or in the form of a Qualified Joint and Survivor Annuity if you are married, unless you elect one of the other forms of payment. If the Disability Initial Claims Committee or the Retirement Board determines you are no longer totally and permanently disabled after you have reached your normal retirement date, the sum of your benefit credits will be substituted for your previous disability benefit, and your monthly retirement benefit will not be more than the actuarial equivalent of the sum of your benefit credits.

After conversion of your total and permanent disability benefit to a retirement benefit, you will continue to receive a monthly $100 (or $75 if you received an early payment benefit) *Dependent* child benefit for as long as you remain totally and permanently disabled and continue to have a *Dependent* child under age 19 (or 23 if in college).

What Are Your Line-of-Duty Disability Benefits?

Amount

If you are eligible for line-of-duty disability benefits, your benefits will equal the greater of:

- 100% of your benefit credits for *Credited Seasons* as of the date the disability occurs (including the benefit credit for the *Plan Year* in which the disablement occurs) if you reported to at least one official pre-season training camp or official practice session during the *Plan Year*, or
- $1,000 a month.

Payment and Duration

You will begin to receive your monthly line-of-duty disability benefit as of the first day of the month following the date your disability qualifies as a "substantial disablement." Your benefits will continue as long as your disability qualifies as a "substantial disablement," but not for longer than ninety (90) months. You must submit to any required physical examination to be eligible for line-of-duty disability benefits. Reexaminations to determine your continued eligibility generally will occur at two and five years after you begin to receive line-of-duty disability benefits. However, three or more voting members of the Retirement Board may require you to submit to more frequent examinations, at the expense of the Plan, but not more frequently than every 6 months. If the Disability Initial Claims Committee or the Retirement Board determines that your disability no longer qualifies as a "substantial disablement," your benefits will stop.

Can You Receive Both the Line-of-Duty Disability Benefit and the Total and Permanent Disability Benefit at the Same Time?

No, but if you qualify for both benefits, you will receive whichever is the greater benefit; after the line-of-duty disability benefit payment expires, you will receive any total and permanent disability benefits for which you qualify at that time.

What About Your Entitlement to the Other (Non-Disability) Plan Benefits After Your Disability Benefits Expire?

If you are a *Vested Player* who has collected disability benefits, all other (non-disability) Plan benefits to which you are entitled – for example, pension, death, and survivor protection, and optional forms of payment – will apply as provided under the Plan. These benefits are in addition to any disability benefit you may be entitled to receive, although you would not, of course, receive both a pension benefit and a disability benefit for the same period of time.

REVISED 3/18/04

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN

APPLICATION FOR RETIREMENT BENEFIT

(FOR VESTED PLAYERS ONLY)

Please complete the following steps. Upon receiving a completed application, the Plan Office will send you an Election Form to choose your retirement benefit and an estimate of how much you will receive under the options for which you are eligible.

1. Provide the Player, Player Spouse, and/or Player Beneficiary information on this form.

2. Provide a copy of ONE of the following documents for you, for your spouse if you are married, and for your beneficiary if you wish to name one:

   - Birth certificate;
   - Baptismal certificate or certification of date of birth as shown by church record, certified by custodian of such records;
   - Notification of registration of birth in a public registry of vital statistics;
   - Hospital records of date of birth, certified by custodian of such records;
   - Military service record;
   - Naturalization record;
   - Foreign government or church record; or
   - Passport.

3. Return this form and required documents to:

   Bert Bell/Pete Rozelle NFL Player Retirement Plan
   200 St. Paul Place, Suite 2420
   Baltimore, MD 21202

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN

You may use this form to apply for a Normal (age 55), Deferred (after age 55), or Early (before age 55) retirement benefit for which you are eligible.

- All vested players may retire on or after their 55th birthday.
- If you have a Credited Season before the 1993 Season you may elect retirement as early as your 45th birthday. You may not elect this benefit while employed by an NFL Club. Once you begin receiving your retirement benefit, your surviving wife or minor children will not be eligible to receive pre-retirement death benefits, and you will not be eligible to receive total and permanent disability benefits.
- If you do not have a Credited Season for the 1989, 1990, 1991, or 1992 Seasons you must begin to receive your retirement benefit no later than your 65th birthday.
- If you have a Credited Season for any of the 1989, 1990, 1991, or 1992 Seasons you must begin to receive your retirement benefit no later than April 1 following the year in which you attain age 70½.

Benefits payable before age 55 are reduced, and benefits payable after age 55 are increased, to reflect the difference in life expectancy.

You may choose to receive payments in one of the following forms. All of these forms are actuarially equivalent. A player who is married must obtain the consent of his spouse to elect any form other than one that provides a survivor benefit to his spouse of at least 50% of his benefit.

- A Life Only Pension of equal monthly payments ending at your death.
- A Life and 10-Year Certain Pension of equal monthly payments ending at your death or, if later, after 10 years of payments.
- A Qualified Joint and Survivor Annuity of equal monthly payments during your life. After your death, your spouse (if she survives you) will receive 50% of the amount you received for the remainder of her life.
- A Life and Contingent Pension of equal monthly payments during your life. After your death, your beneficiary (if she or he survives you) will receive a percentage (chosen by you) of the amount you received for the remainder of their life. If your beneficiary is someone other than your wife and is more than 10 years younger than you, IRS rules may limit the percentage of your pension that your beneficiary may receive after your death.
- A Life Only Pension with Social Security Adjustment of higher monthly payments until you reach age 62, and lower payments for the remainder of your life. This form of payment may be elected only if you have a Credited Season before 1993 and you have not yet reached age 62.

You will receive more information about these options, including a calculation of how much you will receive under the options for which you are eligible.

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
APPLICATION FOR RETIREMENT BENEFIT

PLAYER INFORMATION
(please type or print)

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
	/ /	– –

ADDRESS

_____
NO. & STREET

_____
CITY STATE ZIP CODE

TELEPHONE (DAY)

( ) –

MARITAL STATUS (CHECK ONE) ☐ SINGLE ☐ MARRIED (IF MARRIED, PLEASE COMPLETE THE FOLLOWING)

SPOUSE'S NAME _____

SPOUSE'S ADDRESS _____

SPOUSE'S SOCIAL SECURITY NO. _____ SPOUSE'S DATE OF BIRTH ___/___/___

TELEPHONE (EVENING)

( ) –

BENEFICIARY INFORMATION (PLEASE COMPLETE ONLY IF YOU ARE INTERESTED IN THE LIFE AND CONTINGENT ANNUITANT PENSION)

BENEFICIARY'S NAME _____

BENEFICIARY'S RELATIONSHIP TO YOU _____

BENEFICIARY'S SOCIAL SECURITY NO. _____ BENEFICIARY'S DATE OF BIRTH ___/___/___

ACKNOWLEDGMENT

I certify that all of the information provided on or with this application is, to the best of my knowledge, true, accurate, and complete.

Signature _____ Date _____

MAIL COMPLETED APPLICATION TO PLAN OFFICE:

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
Suite 2420, 200 St. Paul Place, Baltimore, MD 21202-2040
(410) 685-5069 ■ (800) 638-3186

REVISED 3/18/04

Bert Bell/Pete Rozelle NFL Player Retirement Plan

Application for Dependent Children Benefits

Instructions

The Bert Bell/Pete Rozelle NFL Player Retirement Plan provides additional benefits to players who are receiving total and permanent disability benefits and who have dependent children. The amount of this benefit is $100 a month (or $75 a month if you received an early payment benefit) per dependent child. In general, a child is considered a dependent if the child receives over half of his or her support from you and the child is under the age of 19, or under the age of 24 if the child is a student.

To apply for dependent children benefits, please complete this form and return it to the Plan Office. You must submit evidence that you provide over half of the support for each child. Your application will not be complete, and will not be considered, until you submit all information and documents requested in this application.

Player Information

Name_____

Date of Birth_____ Social Security No._____

Address (No., Street)_____ Home Phone_____

City, State, Zip_____ Office Phone_____

Dependent Child Information

Please enter below the name, date of birth, and residence address of each child who is your dependent and attach a copy of the birth certificate for each child. For each child age 19 or older, please also attach school enrollment verification, such as a letter from the college's registrar. Attach extra sheets if necessary.

1. Name of Child_____ Date of Birth_____

Residence Address_____

2. Name of Child_____ Date of Birth_____

Residence Address_____

3. Name of Child_____ Date of Birth_____

Residence Address_____

4. Name of Child_____ Date of Birth_____

Residence Address_____

5. Name of Child_____ Date of Birth_____

Residence Address_____

REVISED 3/18/04

Further Information on Dependent Children

Please enter below the reason (for example, school, divorce, hospitalization) for each child whose residence address is different than the Player's home address. You must attach additional evidence of dependency for each child listed below, such as a sworn declaration by you stating the approximate monthly expenses for such child and the amount of support you provide each month.

1. Name of Child_____

Reason_____

2. Name of Child_____

Reason_____

3. Name of Child_____

Reason_____

4. Name of Child_____

Reason_____

5. Name of Child_____

Reason_____

Signature

I certify that the information provided on or with this form is, to the best of my knowledge, true, correct, and complete. I agree that, to verify information reported in this form, I will provide such additional information or documents requested to verify information reported herein or to demonstrate that I am entitled to Dependent Children Benefits.

Player's Signature_____ Date_____

Mail Completed Form to: **Bert Bell/Pete Rozelle NFL Player Retirement Plan**
200 St. Paul Place, Suite 2420
Baltimore, Maryland 21202-2040
(410) 685-5069 (800) 638-3186

REVISED 3/18/04

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN

APPLICATION FOR DEATH BENEFITS

IMPORTANT REMINDERS

- READ ALL EXPLANATIONS AND INSTRUCTIONS CAREFULLY AND REFER TO THE SUMMARY PLAN DESCRIPTION, OR "SPD," OF THE RETIREMENT PLAN FOR MORE INFORMATION REGARDING RETIREMENT AND DEATH BENEFITS
- FILL OUT APPLICATION COMPLETELY
- RETURN APPLICATION AND REQUIRED DOCUMENTATION TO:

  BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
  SUITE 2420
  200 ST. PAUL PLACE
  BALTIMORE, MARYLAND 21202-2040

- PLEASE PROVIDE A COPY OF ***ONE*** OF THE FOLLOWING:
  - Birth Certificate;
  - Baptismal Certificate or Certification of Date of Birth as shown by church record, certified by custodian of such records;
  - Notification of Registration of Birth in a public registry of vital statistics;
  - Hospital Records of Date of Birth, certified by custodian of such records;
  - Military Service Record;
  - Naturalization Record;
  - Foreign government or church record; **or**
  - Passport
- PLEASE PROVIDE A COPY OF THE PLAYER'S DEATH CERTIFICATE
- IF YOU ARE A WIDOW, PLEASE PROVIDE A COPY OF THE MARRIAGE CERTIFICATE
- IF YOU ARE A SURVIVING MINOR CHILD OR IF YOU REPRESENT A SURVIVING MINOR CHILD, PLEASE CONTACT THE PLAN OFFICE FOR FURTHER INFORMATION AT THE ABOVE ADDRESS OR BY TELEPHONE AT 1-800-638-3186

EXPLANATION OF ELIGIBILITY

The Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Retirement Plan") provides death benefits to the widows of eligible Players who die before their retirement benefits begin. The Retirement Plan also provides death benefits to the surviving minor children of eligible Players who die before their retirement benefits begin if there is no surviving spouse or if the surviving spouse has remarried. A child will be considered to be a minor child for this purpose until he or she reaches age 19 (or age 23 if in college), or continuously if mentally or physically incapacitated. Death benefits will begin to be paid as soon as practicable after this application and all required documents are received by the Plan Office.

FORMS OF PAYMENT

The Plan allows surviving spouses of eligible Players who die before their retirement benefit begins to choose between two types of death benefits. This application shows the amount that you would receive under each benefit. Surviving minor children receive death benefits only in the form of **Widow's and Surviving Children's Death Benefits**, as described below.

Widow's and Surviving Children's Death Benefits commence on the first day of the month following the Player's death and, if you are a widow, will be payable until your death or remarriage (whichever occurs first). In the event of your death or remarriage, the monthly benefit will continue to any surviving minor children of the Player until the last of such children reaches age 19 (or age 23 if in college), or continuously for any child who is mentally or physically incapacitated.

Spouse's Pre-Retirement Death Benefits commence on the first day of the month following the Player's death, or if later, the date he would have reached age 55, or age 45 if he had a Credited Season prior to the 1993 Plan Year, had he lived to that date. The benefits continue for your lifetime only.

TAX WITHHOLDING

For purposes of tax withholding, your monthly death benefit is divided into two portions. One portion is the amount that does not exceed the Widow's Annuity Benefit (the greater of (a) 50% of the Player's Benefit Credits or (b) $1,200), and the other portion is the amount in excess of the Widow's Annuity Benefit.

The portion that does not exceed the Widow's Annuity Benefit is subject to federal income tax withholding unless you elect to have no withholding. In the Tax Withholding section I of the application, please check either Box A (no withholding) or Box B (withholding) below to make your election. If you choose Box B and elect withholding, you also must also note your marital status and claim an appropriate number of withholding exemptions. You may use the enclosed Internal Revenue Service Form W-4P to determine the appropriate number of withholding exemptions. You do not have to complete Form W-4P. We will use this information to compute the amount we must withhold from your check using appropriate withholding tables. Your election will remain in effect until you revoke it. You may revoke your election at any time, and you may change your election as often as you wish by completing a new Tax Withholding portion of this application Your election will take effect as soon as administratively practicable. If you do not check either Box A or Box B, federal income tax will be withheld from your benefit payments using withholding rates applicable to a married individual claiming three withholding exemptions. The portion that does not exceed the Widow's Annuity Benefit is subject to federal income tax, regardless of how you complete the Tax Withholding section of the application. If you elect no withholding from your benefit payments or if you do not have enough federal income tax withheld from your benefit payments, you may be responsible for payment of estimated tax. You may incur tax penalties under the estimated tax payment rules if your withholding and estimated tax payments are not sufficient. You may want to consult a tax advisor to determine if tax withholding on your benefit payments is appropriate. This portion of your monthly death benefit is not eligible for rollover to an IRA or other eligible employer plan, and is taxable income to you for purposes of federal income tax.

Federal law requires that 20% of the portion of the monthly death benefit in excess of the Widow's Annuity Benefit is subject to mandatory income tax withholding, unless you elect to make a "DIRECT ROLLOVER" of such excess amount to a traditional Individual Retirement Account or Annuity ("IRA"). The enclosed Special Tax Notice Regarding Retirement Plan Payments sets forth more information concerning the tax treatment of this distribution. The Tax Withholding section II of the application allows you to select the form of payment for withholding tax purposes and to elect or decline a DIRECT ROLLOVER with respect to this portion of your death benefits.

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
APPLICATION FOR DEATH BENEFITS

PLAYER INFORMATION
(please type or print)

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF DEATH (ATTACH DEATH CERTIFICATE)
	/ /	- -	

SURVIVING SPOUSE INFORMATION

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF MARRIAGE (ATTACH MARRIAGE CERTIFICATE)
	/ /	- -	

ADDRESS

_____
NO. & STREET

_____
CITY STATE ZIP CODE

TELEPHONE (DAY)
( ) -

TELEPHONE (EVENING)
( ) -

SURVIVING CHILDREN INFORMATION

NAME OF CHILD _____ DATE OF BIRTH _____

NAME OF CHILD _____ DATE OF BIRTH _____

NAME OF CHILD _____ DATE OF BIRTH _____

NAME OF CHILD _____ DATE OF BIRTH _____

NAME OF CHILD _____ DATE OF BIRTH _____

FORM OF BENEFIT

I elect death benefits in the following form (select one only):

☐ **WIDOW'S AND SURVIVING CHILDREN'S BENEFITS** beginning on _____ (effective date) in the monthly benefit amount of $_____ for 48 months and $_____ thereafter until my death or remarriage and thereafter to any surviving minor children.

☐ **SPOUSE'S PRE-RETIREMENT DEATH BENEFITS** beginning on _____ (effective date) in the monthly benefit amount of $_____ payable for my entire life.

TAX WITHHOLDING

SECTION I (applicable only to the portion of the death benefit not in excess of the Widow's Annuity Benefit; please check one only)

☐ **Box A: No Withholding**
I DO NOT WANT to have federal income tax withheld from my payments. (This election is not available if you are a U.S. citizen or resident alien, and your payment is to be delivered outside of the United States or its possessions.)

☐ **Box B: Withholding**
I WANT to have federal income tax withheld from my payments. (If you checked Box B, please complete Part B1 below. You also may complete Part B2 if you want to withhold an additional amount.)

Part B1: The total exemptions I am claiming are ____, and my marital status is ____ SINGLE / ____ MARRIED / or ____ MARRIED BUT WITHHOLD AT HIGHER SINGLE RATE (check one).

Part B2: I WANT to withhold an additional dollar amount from each payment of $_____ (must exceed $5.00).

SECTION II (applicable only to the amount of the death benefit in excess of the Widow's Annuity Benefit; please check one only)

- ☐ **Option 1.** I elect to have the amount of the death benefit in excess of the Widow's Annuity Benefit made payable directly to me. I understand that 20% of this amount will be withheld for federal income tax purposes.
- ☐ **Option 2.** I elect to have the amount of the death benefit in excess of the Widow's Annuity Benefit sent to me but made payable directly to my IRA or to another eligible employer plan.
- ☐ **Option 3.** I elect to have a portion of the amount of the death benefit in excess of the Widow's Annuity Benefit sent to me but made payable directly to my IRA or to another eligible employer plan, and the remainder of such excess amounts made payable directly to me. The allocation of the two amounts is as follows:

(a)	Amount to be made payable to my IRA or to another eligible employer plan (not less than $500)	$ _____
(b)	Amount to be made payable to me (which will be subject to 20% tax withholding)	$ _____
(c)	Total death benefit in excess of the Widow's Annuity Benefit (the sum of (1) and (2) must equal this amount)	$ _____

Rollover Information

Please complete this section only if you checked Option 2 or 3 above.

I hereby direct that all (Option 2) or a portion (Option 3) of the amount of the death benefit in excess of the Widow's Annuity Benefit shown above is to be made payable to the IRA or eligible employer plan:

Name of financial institution (trustee) maintaining the IRA _____
OR
Name of eligible employer plan _____

Address _____

Contact Person _____ Phone No. _____

Account No. _____

SIGNATURE

I certify that I was married to _____ (Player name) on the Date of Marriage shown above and was still his wife at the time of his death. I further certify that all the information provided on or with this application is, to the best of my knowledge, true, correct, and complete.

I understand the terms and conditions of the two death benefits described above and the financial effect of one such benefit over the other.

I acknowledge that I have read the Special Tax Notice Regarding Retirement Plan Payments, have been advised of the tax consequences of my distribution, and have made and understand the tax withholding election checked above. I acknowledge that I have at least 30 days following receipt of the Special Tax Notice Regarding Retirement Plan Payments to consider my direct rollover options. I acknowledge that my return of this application before the end of this 30-day period constitutes a waiver of my right to additional time to consider my direct rollover options.

Surviving Spouse's Signature _____ Date _____

MAIL COMPLETED APPLICATION TO PLAN OFFICE:

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
Suite 2420, 200 St. Paul Place, Baltimore, MD 21202-2040
(410) 685-5069 ■ (800) 638-3186

REVISED 3/18/04

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN

APPLICATION FOR EARLY PAYMENT BENEFIT

(FOR PLAYERS ONLY)

Please complete the following steps. Upon receiving a completed Application, the Plan Office will send you an Election Form to choose your early payment benefit and an estimate of how much you will receive under different optional forms of payment.

1. Provide the Player and Player Spouse information requested in this Application.

2. Provide a copy of ONE of the following documents for you and for your spouse if you are married:

   - ξ Birth certificate;
   - ξ Baptismal certificate or certification of date of birth as shown by church record, certified by custodian of such records;
   - ξ Notification of registration of birth in a public registry of vital statistics;
   - ξ Hospital records of date of birth, certified by custodian of such records;
   - ξ Military service record;
   - ξ Naturalization record;
   - ξ Foreign government or church record; or
   - ξ Passport.

3. Return this Application and required documents to the Plan Office:

   Bert Bell/Pete Rozelle NFL Player Retirement Plan
   200 St. Paul Place, Suite 2420
   Baltimore, MD 21202

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
APPLICATION FOR EARLY PAYMENT BENEFIT

You may elect an Early Payment Benefit if you have a Credited Season before 1993 and your playing career ended after February 28, 1977. You may not elect an Early Payment Benefit while employed by an NFL Club.

By electing this Early Payment Benefit you will reduce by 25% the amount of any retirement, disability, or death benefits that later may be payable to you or your beneficiaries. **You should carefully consider this reduction before electing an Early Payment Benefit.**

You may receive your Early Payment Benefit in one of the following forms. All of these forms are actuarially equivalent. If you are married, you must obtain the consent of your spouse to elect any form other than the Qualified Joint and Survivor Annuity.

- A Lump Sum equal to 25% of the present value of your total benefit credits.
- A Life Only Pension (based on 25% of the present value of your benefit credits) of equal monthly payments ending upon your death.
- A Qualified Joint and Survivor Annuity (based on 25% of the value of your benefit credits) of equal monthly payments during your life. After your death, your spouse (if she survives you) will receive 50% of the amount you received for the remainder of her life.

PLAYER INFORMATION
(please type or print)

NAME

DATE OF BIRTH / /

SOCIAL SECURITY NUMBER – –

ADDRESS

No. & STREET

CITY STATE ZIP CODE

TELEPHONE (DAY) ( ) –

MARITAL STATUS (CHECK ONE) ☐ SINGLE ☐ MARRIED (IF MARRIED, PLEASE COMPLETE THE FOLLOWING)

SPOUSE'S NAME

SPOUSE'S ADDRESS

SPOUSE'S SOCIAL SECURITY NO. SPOUSE'S DATE OF BIRTH / /

TELEPHONE (EVENING) ( ) –

ACKNOWLEDGMENT

I certify that all of the information provided on or with this Application is, to the best of my knowledge, true, correct, and complete. I have left football permanently and do not expect to return. I hereby apply for my Early Payment Benefit. I understand that receipt of an Early Payment Benefit will reduce my later retirement benefits under the Retirement Plan by 25%, and will also reduce by 25% (i) the amount of any disability benefits that I may become eligible for at any later date, (ii) any widow's and surviving children's benefits that may be payable after my death, and (iii) any spouse's pre-retirement death benefit that may be payable after my death.

Signature_____ Date_____

MAIL COMPLETED APPLICATION TO PLAN OFFICE:

BERT BELL/PETE ROZELLE NFL PLAYER RETIREMENT PLAN
Suite 2420, 200 St. Paul Place, Baltimore, MD 21202-2040
(410) 685-5069 ■ (800) 638-3186

NFL PLAYER

SECOND CAREER SAVINGS PLAN

APPLICATION FOR DISTRIBUTION

(FOR PLAYERS ONLY)

IMPORTANT REMINDERS

- READ ALL EXPLANATIONS AND INSTRUCTIONS CAREFULLY
- FILL OUT APPLICATION COMPLETELY
- COMPLETE BENEFICIARY DESIGNATION FORM IF YOU ELECT TO RECEIVE THE TOTAL VALUE OF YOUR SAVINGS ACCOUNT UNDER THE TEN YEAR INSTALLMENT OPTION, AND IF YOU WANT TO NAME OR CHANGE YOUR BENEFICIARY
- RETURN APPLICATION AND REQUIRED DOCUMENTATION TO:

  NFL PLAYER SECOND CAREER SAVINGS PLAN
  SUITE 2420
  200 ST. PAUL PLACE
  BALTIMORE, MARYLAND 21202-2040

- PLEASE PROVIDE A COPY OF ***ONE*** OF THE FOLLOWING FOR YOURSELF. IF YOU ARE ELECTING A QUALIFIED JOINT AND SURVIVOR ANNUITY, YOU MUST ALSO PROVIDE A COPY OF ***ONE*** OF THE FOLLOWING FOR YOUR WIFE:
  - Birth Certificate;
  - Baptismal Certificate or Certification of Date of Birth as shown by church record, certified by custodian of such records;
  - Notification of Registration of Birth in a public registry of vital statistics;
  - Hospital Records of Date of Birth, certified by custodian of such records;
  - Military Service Record;
  - Naturalization Record;
  - Foreign government or church record; **or**
  - Passport.

NFL PLAYER SECOND CAREER SAVINGS PLAN

EXPLANATION OF ELIGIBILITY

You are eligible to receive a distribution of your Savings Account under the NFL Player Second Career Savings Plan ("Savings Plan") at any time after the earlier of when you (a) attain age 45 and are no longer employed by an NFL Club or an affiliate of an NFL Club, or (b) attain age 59 1/2 (regardless of whether you are employed by an NFL Club or an affiliate of an NFL Club). If you do not elect to receive your benefit by the end of the calendar year in which you attain age 65, the entire value of your Savings Account will be distributed in 10 annual installments, with the first installment beginning no later than April 1 of the calendar year after you attain age 65.

DISTRIBUTION OPTIONS

The following forms of distribution of your Savings Account are available to you. Your Savings Account will be valued as of the end of the month in which the Plan Office receives your completed Application for Distribution.

- **LUMP SUM.** The total value of your Savings Account is paid in a lump sum. You must elect whether to have all or a portion of the lump sum paid to you (in which case 20% of the amount paid to you will be withheld for federal income tax) or instead to have all or a portion of the lump sum rolled over to another eligible employer plan or an Individual Retirement Account/Annuity ("IRA"). See the enclosed "Special Tax Notice Regarding Savings Plan Payments" for more information.

- **TEN ANNUAL INSTALLMENTS.** The total value of your Savings Account is paid in annual installments over a 10-year period, with 1/10 of the value of the Savings Account payable when benefits commence, 1/9 of the remaining Savings Account paid one year later, etc. You may elect at any time to receive a lump sum equal to the remaining value of your Savings Account. If you die before receiving all installments under this option, the remainder of your Savings Account will be distributed in a lump sum to your beneficiary. Your beneficiary will be your surviving spouse, unless you have elected another beneficiary **with your spouse's consent**.

- **LIFE ANNUITY.** The total value of your Savings Account is used to purchase an annuity contract from an insurance company which provides payments to you for your life only. If you are married, you must sign a written waiver and **obtain the consent of your spouse**.

- **QUALIFIED JOINT AND SURVIVOR ANNUITY.** The total value of your Savings Account is used to purchase an annuity contract from an insurance company which provides payments to you for your life. If your spouse survives you, a payment equal to 50% of the payment you received will be paid to your spouse for the balance of her life. Your surviving spouse is your spouse at the time your annuity distributions begin (unless a Qualified Domestic Relations Order provides otherwise). If you elect this distribution option, your payment will be less than the payment you would have received if you had elected a life annuity in order to reflect the value of the contingent payments to your spouse. **You may elect this option only if you are married.**

The Savings Board may request any information that it deems necessary for the proper administration of these benefits. Any option elected will be irrevocable once benefits begin.

NFL PLAYER SECOND CAREER SAVINGS PLAN
APPLICATION FOR DISTRIBUTION

INSTRUCTIONS

To apply for a distribution, please complete this application, sign in the space provided, include all required documentation, and return it to the Plan Office. If you elect to receive the total value of your Savings Account in installments, and if you want to name or change your beneficiary, please also complete a Designation of Beneficiary Form.

PLAYER INFORMATION *(please type or print)*

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
	/ /	– –

ADDRESS

_____
NO. & STREET

_____
CITY STATE ZIP CODE

TELEPHONE (DAY) ( ) –

CURRENT EMPLOYER

NAME: _____

TELEPHONE (EVENING) ( ) –

MARITAL STATUS (CHECK ONE) ☐ SINGLE ☐ MARRIED

If Married, Spouse's Name _____ Social Security No. ___ - ___ - ___ Date of Birth ___/___/___

BENEFIT DISTRIBUTION AND TAX WITHHOLDING

You must elect a distribution and tax withholding option below. If you elect a Lump Sum, do not complete the tax withholding section.

A. DISTRIBUTION OPTION

☐ **LUMP SUM** –Under this option, you must elect to have the lump sum paid as follows:

☐ **1.** I elect to have my Savings Account **paid directly to me.** I understand that 20% of the amount will be withheld for federal income tax purposes.

☐ **2.** I elect a DIRECT ROLLOVER of my entire Savings Account **to my IRA or to another eligible employer plan.**

☐ **3.** I elect a DIRECT ROLLOVER of a portion of my Savings Account **to my IRA or to another eligible employer plan**, and the remainder made payable directly to me. The allocation of the two amounts is as follows:

(a) DIRECT ROLLOVER amount to my IRA or to another plan (not less than $200): _____%

(b) Amount to be made payable to me (subject to 20% tax withholding): _____%

TOTAL 100%

DIRECT ROLLOVER INFORMATION: **Complete this section only if Box 2 or Box 3 was checked above.**

I request that all or a portion of my Savings Account be paid directly to the IRA or eligible employer plan indicated below:

Name of financial institution (Trustee) maintaining the IRA: _____

Account Number of IRA: _____

-OR-

Name of eligible employer plan: _____

Address: _____

Contact Person: _____ Telephone Number: _____

☐ **TEN ANNUAL INSTALLMENTS** – Your Savings Account will be paid to you over a 10-year period, with 1/10 of the value of your Savings Account paid when benefits commence, 1/9 of the remaining value paid one year later, etc.

☐ **LIFE ANNUITY** – Your Savings Account will be used to purchase an annuity contract that will pay you in the form of annuity payments over your life. If you are married, you must obtain your spouse's consent to elect this option. The Plan Office will send you the appropriate documents to implement this consent.

☐ **QUALIFIED JOINT AND SURVIVOR ANNUITY** – Your Savings Account will be used to purchase a commercial annuity contract under which you will receive reduced annuity payments over your life, with 50% continuation payments over the life of your spouse, if she survives you. You must be married to elect this option.

TAX WITHHOLDING

Complete this part only if you have selected Ten Annual Installments, a Life Annuity, or a Qualified Joint and Survivor Annuity. Skip over this part if you have selected a Lump Sum.

The benefit payments you will receive are subject to federal income tax withholding **unless you elect** to have no withholding. Please check either Box A (no withholding) or Box B (withholding) below to advise us of your election. If you choose Box B and direct us to withhold, you must also tell us your marital status and claim an appropriate number of withholding exemptions. You may use the enclosed Internal Revenue Service Form W-4P to determine the appropriate number of withholding exemptions. You do not have to complete Form W-4P. We will use this information to compute the amount we must withhold from your check using appropriate wage withholding tables. Your election will remain in effect until you revoke it. You may revoke it at any time and you may change your election as often as you wish by completing a new Tax Withholding portion of this application. Your election will take effect as soon as administratively practicable.

If you do not check any box, **federal income tax will automatically be withheld** from your benefit payments using withholding rates applicable to a married individual claiming three withholding exemptions.

If you elect to have no withholding from your benefit payments or if you do not have enough Federal income tax withheld from your benefit payments, you may be responsible for payment of estimated tax. **You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.** For additional instructions, consult the instructions to IRS Form W-4P or IRS Publication 505. You may want to consult a tax advisor to determine if withholding on your benefit payments is appropriate.

CHECK ONLY ***ONE*** BOX BELOW TO ADVISE US OF YOUR ELECTION.
IF YOU SELECT MORE THAN ONE BOX, YOUR ELECTION WILL BE INVALID.

☐ **BOX A: NO WITHHOLDING**
I DO NOT WANT to have federal income tax withheld from my payments. (This election is not available if you are a U.S. citizen or resident alien, and your payment is to be delivered outside of the United States or its possessions.)

☐ **BOX B: WITHHOLDING**
I WANT to have federal income tax withheld from my payments. (If you checked Option B, please complete Part B1 below. You also may complete Part B2 if you want to withhold an additional amount.)

Part B1: The total exemptions I am claiming are ____, and my marital status is ____ SINGLE / ____ MARRIED / or ____ MARRIED BUT WITHHOLD AT HIGHER SINGLE RATE (check one).

Part B2: I WANT to withhold an additional dollar amount from each payment of $_____ (must exceed $5.00).

ACKNOWLEDGMENT

In requesting a distribution from the Savings Plan, I hereby certify that I have read this Application for Distribution and that all information that I have provided on or with this application is, to the best of my knowledge, true, correct, and complete. I acknowledge that I have received a copy of the Special Tax Notice Regarding Savings Plan Payments and that I have made the elections checked above. I understand that any distribution options elected will become irrevocable as of the benefit commencement date. I further acknowledge that payments will not commence for at least 30 days after I have received this application, unless I complete and return this application before the end of the 30-day period. I further acknowledge that, if I elect a Life Annuity or a Qualified Joint and Survivor Annuity, payments may not commence before the expiration of the 7-day period that begins on the day after I received this application.

I acknowledge that I have at least 30 days following receipt of the Special Tax Notice Regarding Savings Plan Payments to decide whether or not I want a direct rollover of my lump sum distribution. I also acknowledge that my return of this application to the Plan Office before the end of the 30-day period constitutes a waiver of my rights to any additional time for consideration of my options and authorizes payment of my benefits, or direct rollover, as elected, before the expiration of the 30-day period.

Signature_____ Date_____

MAIL COMPLETED APPLICATION TO PLAN OFFICE:
NFL PLAYER SECOND CAREER SAVINGS PLAN
Suite 2420, 200 St. Paul Place, Baltimore, MD 21202-2040
(410) 685-5069 ■ (800) 638-3186

NFL PLAYER

ANNUITY PROGRAM

APPLICATION FOR DISTRIBUTION

(FOR PLAYERS ONLY)

IMPORTANT REMINDERS

- READ ALL EXPLANATIONS AND INSTRUCTIONS CAREFULLY
- FILL OUT APPLICATION COMPLETELY
- RETURN APPLICATION AND REQUIRED DOCUMENTATION TO:

  NFL PLAYER ANNUITY PROGRAM
  SUITE 2420
  200 ST. PAUL PLACE
  BALTIMORE, MARYLAND 21202-2040

- PLEASE PROVIDE A COPY OF ***ONE*** OF THE FOLLOWING FOR YOURSELF. ***IF*** YOU ARE ELECTING A JOINT AND SURVIVOR ANNUITY, YOU MUST ALSO PROVIDE A COPY OF ***ONE*** OF THE FOLLOWING FOR YOUR BENEFICIARY:
  - Birth Certificate;
  - Baptismal Certificate or Certification of Date of Birth as shown by church record, certified by custodian of such records;
  - Notification of Registration of Birth in a public registry of vital statistics;
  - Hospital Records of Date of Birth, certified by custodian of such records;
  - Military Service Record;
  - Naturalization Record;
  - Foreign government or church record; **or**
  - Passport.

NFL PLAYER ANNUITY PROGRAM

EXPLANATION OF ELIGIBILITY

To receive a distribution under the NFL Player Annuity Program ("Annuity Program"), (1) you must be age 45 or older, or (2) you must be age 35 or older and at least five years must have elapsed since the March 31 following the season in which you earned your last Credited Season. Distributions must begin no later than age 65. You may elect to receive your benefits in different ways.

DISTRIBUTION OPTIONS

The following forms of distribution are available to you. Your account will be valued as of the last day of the month in which your completed application is received by the Program Office. If you would like an estimate of the monthly amounts you would receive under the installment and annuity options, please contact the Program Office.

- **LUMP SUM/PARTIAL LUMP SUM.** You may elect to receive (1) a lump sum or (2) a partial lump sum, with the rest of your account balance paid in one of the alternate forms described below. You must be age 45 or older at the time of distribution to elect this option.

- **INSTALLMENTS.** You may elect to receive annual amounts until age 45, or for a greater number of years if you wish. Each year you will receive a fraction of your account based on the number of remaining payments. For example, if you elect to receive installments when you turn 35 (assuming you are eligible) until age 45, you will receive your account in 11 installments. Under these facts, you would receive 1/11 of your account in the first year, 1/10 of the remainder of your account in the second year, and so on. If you elect installments until age 45, which is the most rapid form of distribution, your account may be invested more conservatively to provide greater protection of principal. If you elect to receive installments over a period that equals or exceeds your life expectancy the penalty tax on pre-59 ½ withdrawals does not apply (see enclosed Special Tax Notice Regarding Annuity Program Payments).

- **SINGLE LIFE ANNUITY.** You may elect to receive a monthly annuity for your life only. If you are married, you must **obtain the written consent of your spouse.**

- **JOINT AND SURVIVOR ANNUITY.** You may elect to receive a monthly annuity for your life, with a percentage, specified by you, of the benefit amount you received while you were alive to be paid to your beneficiary for life if you die before your beneficiary dies. If your beneficiary dies before you die, then no benefits are paid after your death. If you are married at the time benefits are to begin and you elect a Single Life Annuity, your benefit instead must be paid as a Joint and Survivor Annuity, with your spouse as your beneficiary and a survivor percentage of 50% or greater (a Qualified Joint and Survivor Annuity), unless you and your spouse consent to the Single Life Annuity. Your surviving spouse is your spouse at the time when your annuity distributions begin (unless a Qualified Domestic Relations Order provides otherwise). The monthly annuity under this option is less than the amount that would be paid under a Single Life Annuity. The amount of the reduction depends on your expected life span and your beneficiary's expected life span.

Once benefits begin, the form of distribution cannot be changed.

NFL PLAYER ANNUITY PROGRAM APPLICATION FOR DISTRIBUTION

INSTRUCTIONS

To apply for a distribution, please complete this application, sign in the space provided, include all required documents, and return it to the Program Office.

PLAYER INFORMATION
(please type or print)

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
	/ /	– –

ADDRESS

_____
NO. & STREET

_____
CITY STATE ZIP CODE

TELEPHONE
(DAY) ( ) –

CURRENT EMPLOYER
NAME: _____

TELEPHONE
EVENING) ( ) –

MARITAL STATUS (CHECK ONE) ☐ SINGLE ☐ MARRIED
If Married, Spouse's Name _____ Social Security No.___-___-_____ Date of Birth ___/___/_____

BENEFIT DISTRIBUTION ELECTION

Age 45 Options: Available only if you are age 45 or older. I elect (choose A or B):

A. Lump Sum ☐
To receive my entire account balance in a lump sum.

B. Partial Lump Sum ☐
To receive _____% of my account balance in a lump sum and the remainder in one of the general options indicated below.

General Options: Available at any age, or if you selected option B above. I elect (choose one of C, D, or E):

C. Installments ☐ To receive my account balance in annual amounts until I reach (choose one):

- ☐ Age ___ (must be 45 or older)
- ☐ A period equal to my life expectancy (as determined by Program Office)

D. Single Life Annuity ☐ To receive my account balance in a monthly annuity for my life. After I die, no additional benefits will be paid, even if I have a surviving wife or children at that time.

E. Joint and Survivor Annuity ☐ To receive a reduced monthly annuity during my lifetime, with _____% (insert desired percentage) of the monthly benefit I was receiving paid to the following beneficiary for her (or his) life if she (or he) survives me:

Name of Beneficiary for Installments or Joint and Survivor Annuity (please complete even if you previously designated a beneficiary): _____

Address: _____

Birth date: _____ Relationship to Player: _____
(include evidence of date of birth; see cover sheet)

ACKNOWLEDGMENT

I certify that all of the information provided on or with this form is, to the best of my knowledge, true, accurate and complete. I have read and understand the instructions on this form, and I understand that all of the optional forms of benefits are actuarially equivalent. I hereby irrevocably elect to receive my Annuity Program benefit in the form selected.

I acknowledge that if I elect an annuity and I am married, I have a right to receive my annuity benefit as a Joint and Survivor Annuity with my spouse as beneficiary and with a 50% or greater survivor percentage (a Qualified Joint and Survivor Annuity). I acknowledge that I have at least 30 (but not more than 90) days following receipt of this form to decide whether to waive this right and elect an alternate form of payment. I acknowledge that my return of this form before the end of this 30-day period constitutes a waiver of my right to additional time to consider my options and authorizes payment of my annuity benefits in the form selected. I further acknowledge that the time for consideration of my options does not end before the expiration of the 7-day period which begins on the day after I received this form.

If I am married and I elect an annuity form of payment other than a Qualified Joint and Survivor Annuity, I hereby waive the right to have my annuity benefits paid as a Qualified Joint and Survivor Annuity. I understand that I may revoke this waiver at any time prior to the first day on which my annuity benefits are scheduled to begin, or, if later, the end of the 7-day period discussed above.

Player's Signature_____ Date_____

SPOUSAL CONSENT
MAY BE REQUIRED IF MARRIED – SEE INSTRUCTIONS

I, _____(Print Name) swear that I am the spouse of the above Player. I understand that under federal law I have a right to a survivor's benefit under a Joint and Survivor Annuity equal to 50% of the monthly benefit paid to my husband, if he should die before I die. I waive that right and consent to the form of benefits selected by my husband on this form. I understand that by signing this form, I will receive nothing after my husband dies. I understand that I do not have to sign this form. I am signing this form voluntarily. I understand that my decision is final and that I cannot change this form after I sign it. I understand that if I do not sign this form, then my husband and I will receive payments from the Annuity Program in the form of a Joint and Survivor Annuity with myself as the beneficiary and with a 50% survivor percentage.

Spouse's Signature: _____ Date: _____

The following section is to be completed and notarized by a Notary Public.

State of _____

County of _____

On the _____ day of _____, 20___, before me came_____ to me known and known to me to be the person described herein and who executed the foregoing statement and she duly acknowledged to me that she executed the same.

_____
Notary Public

MAIL COMPLETED FORM TO PROGRAM OFFICE:
NFL PLAYER ANNUITY PROGRAM
Suite 2420, 200 St. Paul Place, Baltimore, MD 21202-2040
(410) 685-5069 ■ (800) 638-3186

88 Plan
Application for Dementia Benefits

Instructions

The 88 Plan was established to pay and reimburse qualifying expenses incurred by or on behalf of eligible NFL Players who have dementia. This application will assist the 88 Plan to determine whether a Player is eligible. It should be carefully completed and sent to the Plan Office with all relevant medical records. To apply for dementia benefits, the Player or his personal representative must complete this application and return it to the Plan Office with all required information. A claim for benefits under the Plan will not be considered filed until the Plan Office receives this application with the required information. In some cases, the 88 Plan may request additional information and may request (and pay for) the Player to be examined by a physician selected by the Plan, and the 88 Plan

Please call the Plan Office (800-638-3186) if there are any questions about this application or the 88 Plan. If this application is approved, forms for the payment of benefits will be provided. Please mail this application and all attachments to:
88 Plan, 200 St. Paul Place, Suite 2420, Baltimore, MD 21202-2040.

Player and Representative Information

Player's name_____ Tel. Number_____

Player's date of birth_____ Player's Social Security Number_____

Player's address_____
Street City State Zip Code

Name of Player's Representative _____

Relationship of Representative to Player_____

Phone number of Representative_____

Address of Representative_____
Street City State Zip Code

Player's Employment and Medical Information and Effective Date

1. Player's Most Recent Employer_____ Player's Job Title_____

   Employer's Address_____

   Reason for Leaving_____

   Job Description and Responsibilities_____

   _____

   Last Day of Employment _____

2. **Medical and Hospital Records:** Enclose copies of all medical and hospital records that relate to this claim for dementia benefits. A copy of these records may be obtained by asking the Player's providers (that is, physicians, hospitals, etc. that have treated the Player) for the Player's records.

Player's Attending Physicians/Institutional Care

1. Please provide the following information for all physicians who have diagnosed the Player as having dementia or who have treated the Player for dementia. Attach additional sheets if more space is needed.

Name of Physician_____ Condition for which seen_____

Dates of Treatment_____ Approximate number or frequency of office visits_____

Physician's Address and Phone Number_____

_____

Name of Physician_____ Condition for which seen_____

Dates of Treatment_____ Approximate number or frequency of office visits_____

Physician's Address and Phone Number_____

_____

Name of Physician_____ Condition for which seen_____

Dates of Treatment_____ Approximate number or frequency of office visits_____

Physician's Address and Phone Number_____

_____

Name of Physician_____ Condition for which seen_____

Dates of Treatment_____ Approximate number or frequency of office visits_____

Physician's Address and Phone Number_____

_____

2. If the Player has been institutionalized (in a hospital or any other facility) for dementia, please list all such institutions and the dates and duration the Player was in that institution.

_____

_____

General Information

Please describe the onset and development of the Player's dementia, his current symptoms, and how those symptoms impact his daily life. Please provide any additional information that may help the 88 Plan determine the Player's eligibility for benefits. Attach additional sheets if more space is needed.

Certification

I certify that all the information provided on and with this application is, to the best of my knowledge, true, correct and complete. I certify that any and all documents or information attached to or enclosed with this application are, to the best of my knowledge, true, correct and complete. I recognize that the Player may lose benefits, and that I may be subject to penalties and sanctions under law, if I have made any false or misleading statements or omissions.

Signature of Player or
His Representative_____ Date_____

Authorization for Use or Disclosure of Individually Identifiable Health Information

This Authorization for Use and Disclosure of Individually Identifiable Health Information must be completed for each player on whose behalf benefits are requested under the 88 Plan (the "Player"). Players will not be eligible for benefits unless this form is completed. This Authorization is intended to comply with HIPAA.

Purpose of This Authorization:
The 88 Plan will use and may disclose individually identifiable health information about the Player for the purpose of making eligibility determinations relating to the Player . For example,

- The Player must submit, or have submitted on his behalf, individually identifiable health information, including without limitation his application, medical records, and physician reports.
- The Player also may be referred to Plan-neutral physicians for medical examination, and these physicians may submit individually identifiable health information to the 88 Plan or the Player.

Individuals or Entities Authorized to Use or Disclose Protected Health Information Pursuant to This Authorization:

- Any and all health care providers who furnished care to the Player (including without limitation any and all health care providers who were involved in diagnosing or treating the Player's dementia) are authorized to disclose individually identifiable health information about the Player to the 88 Plan (including without limitation to the 88 Plan's fiduciaries, , designees, employees, or agents).
- The 88 Plan (including without limitation its fiduciaries, designees, employees, or agents) is authorized to use and disclose individually identifiable health information for plan purposes.

Protected Health Information Authorized to Be Used or Disclosed:
All medical records, reports, test results, notes (excluding psychotherapy notes as defined under 45 C.F.R. § 164.501), and other health information are hereby authorized to be used and disclosed pursuant to this Authorization for Use and Disclosure of Individually Identifiable Health Information. This authorization is intended to cover all individually identifiable health information requested by, created by, or otherwise submitted to the 88 Plan in connection with the application on behalf of the Player for benefits, and should be construed broadly for this purpose.

Player's Name_____

Name of Representative Authorized to Act on Behalf of the Player:

_____

Signature of Player or
His Representative_____ Date_____

Description of Representative's Relationship to the Player and the Basis of Her or His Authority to Act on the Player's Behalf:_____

_____

_____

_____

_____

You are entitled to a copy of this authorization after you sign it. This authorization will remain in effect as long as benefits as sought on behalf of the Player or the Player is eligible for benefits from the 88 Plan. You have the right to revoke this authorization in writing to the 88 Plan, except to the extent that the 88 Plan has relied thereon. Information disclosed pursuant to this authorization may be redisclosed by the recipient(s) and no longer protected by the federal privacy law.