AUTHORIZATION TO TRANSFER
HEALTH & WELFARE and/or PENSION CONTRIBUTIONS

I hereby request that effective _____ , 20____, all contributions received by your Fund as a result of work performed, be transferred to my Home Fund(s).

This authorization shall apply to:
(please check the appropriate box or boxes)

Mail my contributions to:

NAME OF HOME H&W FUND

ADDRESS

CITY STATE ZIP

FUND PHONE NO.

NAME OF HOME PENSION FUND

ADDRESS

CITY STATE ZIP

FUND PHONE NO.

I understand that the above transferring fund or funds from which my designated contributions are transferred will act solely as the agent of my Home Fund(s). I understand that when these transfers are made, I shall no longer have any claim on any fund except my Home Fund(s) for said contributions and/or for benefits which otherwise would accrue through the other funds to my benefit or the benefit of my survivors or beneficiaries based upon said contributions. I understand that my eligibility for benefits based on said contributions shall be determined solely in accordance with the provisions of the Plan or Plans releasing the transferring fund(s) from all claims with respect to any contributions so transferred and for any benefits or credits which would have accrued or become payable to me by the transferring fund(s). This request shall remain in effect until and unless I notify the transferring fund(s) in writing of my desire to revoke this request.

YOUR NAME (Please Print)

SOCIAL SECURITY NUMBER

YOUR STREET ADDRESS

CITY STATE ZIP

PHONE NO.

SIGNATURE DATE

HOME LOCAL CHAPTER

HOME LOCAL ADDRESS

CITY STATE ZIP

PHONE NO.

Mail a copy to the Transferring Pension Fund and the Transferring Health & Welfare Fund