

HEALTH & WELFARE RECIPROCITY

Request and Authorization for Transfer of Contributions

Participant Name (Please Print)

Social Security Number

I request and authorize the Board of Trustees of the Local _____ (local you are working in) Health and Welfare Fund to transfer the Health and Welfare Fund contributions made on my behalf to the Fund I have listed below. This authorization will be effective on the date it is received and within six months prior to that date. This authorization will remain in effect until this authorization is revoked in writing. In support of this request, I state as follows:

1. I am a member of IUOE Local No. _____ (Home Local #) and my Union Register No. is _____.

I want my H & W hours transferred to: (Check only one choice below)

_____ My Home Local

_____ Pipeline H & W.

2. I understand that, upon approval of my request to transfer, I cannot later request that any contributions which may be transferred to my Home Fund be transferred back to the transferring Fund.
3. I understand that, upon approval of my request to transfer contributions, my (and my dependents') eligibility for benefits and all other participant rights shall be determined exclusively by the terms of my Home Fund's plan and rules, and not by the terms of the transferring Fund's plan and rules.
4. By making this request, I waive and release, on behalf of myself and my Dependents, any and all claims against both Funds and their fiduciaries relating to whether the transfer of contributions is in my or their best interests.

Participant's Signature

Date

Street Address

City, State, Zip

Telephone

IUOE LOCALS 181, 320 & TVAHEALTH & WELFARE TRUST FUND
PO BOX 1179
HENDERSON, KY 42419
TEL: 270-826-6750
FAX: 270-826-6770

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