Alaska Carpenters Trust Funds

Alaska Carpenters Health and Welfare Trust Fund • Alaska Carpenters Defined Contribution Trust Fund
Southern Alaska Carpenters Retirement Plan

P.O. Box 34203, Seattle, WA 98124-1203
(800) 541-5357 • Fax (206) 5050-9727

Authorization to Transfer Fringe Benefit Contributions

This authorization applies to your HEALTH & WELFARE and ALL eligible RETIREMENT Benefits.
To be accepted, this authorization must be submitted to the cooperating Trust within 60 days of beginning work in their area.

I am a participant in the Trust Fund identified below (referred to as "Home Trust").

PLEASE PRINT

Home Trust: ______________________________

Address: ______________________________
Street City State Zip

However, for the period beginning ______________, I will be working or have worked in the area covered by the following Trust Fund (referred to as "Cooperating Trust Office").

Cooperating Trust: ______________________________

Address: ______________________________
Street City State Zip

I hereby elect, to the extent that the Trustees of the above "Cooperating Trust" Fund and the Trustees of my "Home Trust" Fund have agreed, through the execution of the International Reciprocal Agreement, to have contributions that were paid on my behalf to the "Cooperating Trust" Fund will act solely as the agent of the "Home Trust" Fund upon the transfer of the contributions.

I hereby release (on behalf of myself as well as on behalf of anyone claiming through me) and further discharge the "Cooperating Trust" Fund and its Trustees of and from all claims, demands, actions, causes of actions, and suits with respect to any contributions so transferred and for any benefits or credits which would have accrued or become payable to me or my beneficiaries had I not authorized this transfer of contributions. I further recognize that the transfer of contributions of the "Home Trust" Fund may or may not ultimately prove to be advantageous to myself and/or my beneficiaries.

This transfer authorization will remain in effect until the last day of the month in which my written request to cancel the authorization has been received by the Administrator of the Cooperating Trust.

Member Name: ______________________________ Home Local No: ______________

Address: ______________________________
Street City State Zip

Social Security No: ______________________ Phone No: (______)______________

Signature: ______________________________ Date: ______________

FORWARD FORMS TO PLAN ADMINISTRATORS IMMEDIATELY AFTER SIGNING

White – Cooperating Trust Yellow – Home Trust Pink – Member