

Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

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Administered by
Labor Trust Services, Inc.

AUTHORIZATION TO TRANSFER FRINGE BENEFIT CONTRIBUTIONS

This authorization applies to your **HEALTH AND 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 to 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 this authorization has been received by the Administrator of the Cooperating Trust.

Member Name: _____ **Home Local No.:** _____

Address: _____
Street City State Zip

Social Security No.: _____ **D.O.B.:** _____ **Phone No.:** _____

Signature: _____ **Date:** _____

FORWARD FORMS TO PLAN ADMINISTRATORS IMMEDIATELY AFTER SIGNING.

White-Cooperating Trust

Yellow-Home Trust

Pink-Member