

**ARIZONA LABORERS AND TEAMSTERS
PENSION TRUST FUNDS**

PENSION TRUST FUND
(Defined Benefit)

ADMINISTRATIVE OFFICE

ANNUITY TRUST FUND
(Defined Contribution)

2400 W. Dunlap Ave., Suite 250
Phoenix, AZ 85021
(602) 249-3582
www.southwestservicetpa.com

January 2010

Dear Recipient,

The Board of Trustees has a fiduciary responsibility to confirm that each eligible pensioner or beneficiary is personally receiving their monthly benefit payment, either by check or direct deposit. The Trustees must also confirm employment status and disability status if a participant is receiving a disability pension. The enclosed affidavit, when completed and returned by each eligible member, will assist the Trustees in protecting your pension benefit.

Please return a completed affidavit form promptly to assure that your future pension payments are not interrupted. We have provided a return envelope for your convenience.

Thank you for your cooperation. If you have any questions or concerns, please telephone the Fund Office.

Sincerely,

Pension Department
Southwest Service Administrators, Inc.

Enclosure

www.southwestservicetpa.com

**Go to www.southwestservicetpa.com to access plan regulations,
recent mailings, and various forms.**

**Also available online is the "Electronic Deposit Authorization Form" that may be
returned to implement the direct deposit of benefits to your bank account.**

Arizona Laborers' & Teamsters Pension Trust Fund

Enero 2010

Estimado Participante,

La Junta de Fiduciarios tienen la responsabilidad fiduciaria de confirmar que cada pensionado o beneficiario esta recibiendo personalmente el pago mensual de beneficios, ya sea por cheque o depósito directo. Los Fiduciarios también deben de confirmar el estatus de empleo y de la discapacidad si un participante está recibiendo una pensión por discapacidad. La declaración adjunta, una vez que la complete y la regrese cada miembro, ayudará a los Fiduciarios en la protección de su pension.

Por favor, regrese el formulario completo a la brevedad posible para asegurar que sus futuros pagos de pension no sean interrumpidos. Hemos proporcionado un sobre de retorno para su conveniencia.

Gracias por su cooperación. Si usted tiene alguna pregunta o dudas, por favor comuníquese a esta oficina.

Atentamente,

Departamento de Pensiones
Southwest Service Administrators, Inc.

Apéndice

www.southwestservicetpa.com

Visite el sitio web **www.southwestservicetpa.com** para acceder a los reglamentos del plan, envios de correo recientes y diversas formas.

Tambien disponible en linea esta la forma "Electronic Deposit Authorization Form" (forma de autorizacion para deposito electronico), la cual puede llenar y regresar para implantar la modalidad de deposito directo de beneficios para su cuenta bancaria.

ARIZONA LABORERS' & TEAMSTERS PENSION TRUST FUND
2010 ANNUAL AFFIDAVIT

I PERSONALLY RECEIVE MY MONTHLY BENEFIT PAYMENT IN THE FORM OF:

- A CHECK DELIVERED TO MY HOME A DIRECT DEPOSIT TRANSFERRED TO MY BANK ACCOUNT

ARE YOU PRESENTLY EMPLOYED OR HAVE YOU BEEN EMPLOYED DURING THE PAST YEAR?

- NO YES

IF YOU ANSWERED YES, PLEASE COMPLETE THE FOLLOWING:

EMPLOYER _____ JOB TITLE _____

FULL TIME PART TIME DATES OF EMPLOYMENT; FROM _____ To _____

LOCAL UNION AFFILIATION: _____

A COPY OF YOUR MOST RECENT INCOME TAX RETURN MAY BE REQUESTED

FEDERAL INCOME TAX WITHHOLDING (CHECK ONE)

- I DO NOT WISH TO CHANGE MY FEDERAL TAX WITHHOLDING AMOUNT.
 I DO WISH TO CHANGE MY FEDERAL TAX WITHHOLDING AMOUNT. PLEASE SEND ME A FEDERAL FORM W-4P

CONFIRMATION OF DISABILITY STATUS

(THIS SECTION TO BE COMPLETED ONLY IF YOU ARE LESS THAN 62 YEARS OF AGE AND RECEIVING A SOCIAL SECURITY DISABILITY PENSION.)

THE ADMINISTRATIVE PROCEDURES OF THE FUND REQUIRE YEARLY UPDATES FROM ALL PARTICIPANTS UNDER 62 YEARS OF AGE WHO HAVE RECEIVED A DISABILITY PENSION

- YES, I AM CURRENTLY RECEIVING A SOCIAL SECURITY DISABILITY PENSION
 NO, I AM NO LONGER RECEIVING A SOCIAL SECURITY DISABILITY PENSION

IF YOU ANSWERED YES, PLEASE SUBMIT A **COPY** OF YOUR MOST RECENT SOCIAL SECURITY DISABILITY CHECK OR A **COPY** OF THE 1099 THAT WAS PROVIDED TO YOU BY THE SOCIAL SECURITY ADMINISTRATION.

CONFIRMATION OF PERSONAL CONTACT INFORMATION (PLEASE PRINT)

NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ XXX-XX-

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____ (_____) _____

NEW MAILING ADDRESS, IF APPLICABLE : _____

CITY _____ STATE _____ ZIP _____

I HEREBY DECLARE UNDER PENALTY OF PERJURY THAT ALL INFORMATION SHOWN BY ME IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE