

**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.southwestservicefpa.com

SECOND REQUEST

February 2011

Dear Recipient,

The Trustees have a fiduciary responsibility to confirm that each eligible pensioner or beneficiary is personally receiving their monthly benefit payment, either by check or direct deposit.

In that regard, the Fund procedures require that you complete and return the enclosed form as soon as possible.

Please note that this is a second request for you to fill out and return the annual affidavit. Failure to return the completed form may interrupt the issuance of your future pension payments.

A return envelope is enclosed for your convenience in returning the form to the Fund Office.

Thank you for your cooperation. If you have any questions or concerns, please call the Fund Office at 602-249-3582.

Sincerely,

Pension Department
Southwest Service Administrators, Inc.

Enclosure

***Go to www.southwestservicefpa.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.***

SEGUNDA SOLICITUD

Febrero 2011

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.

En ese sentido, el Fondo de procedimientos requieren que usted llene y regrese el formulario completo a la brevedad posible.

Tenga en cuenta que se trata de una segunda solicitud para que usted llene y regrese la declaración anual. El hecho de no regresar el formulario completo puede interrumpir la emisión de sus futuros pagos de pensiones.

Hemos proporcionado un sobre de retorno para su conveniencia en el regreso del formulario a la Oficina de Fondo.

Gracias por su cooperación. Si usted tiene alguna pregunta o dudas, por favor comuníquese con Oficina del Fondo a 602-249-3582.

Atentamente,

Departamento de Pensiones
Southwest Service Administrators, Inc.

Apéndice

Visite el sitio web www.southwestservicetpa.com para acceder a los reglamentos del plan, envíos de correo recientes y diversas formas. También disponible en línea esta la forma "Electronic Deposit Authorization Form" (forma de autorización para depósito electrónico), la cual puede llenar y regresar para implantar la modalidad de depósito directo de beneficios para su cuenta bancaria.

ARIZONA LABORERS' & TEAMSTERS PENSION TRUST FUND
2011 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 # _____-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. **AN ORIGINAL SIGNATURE IS REQUIRED FOR THIS DECLARATION.**

SIGNATURE

DATE