

**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

URGENT - FINAL REQUEST

March 9, 2011

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 Board of Trustees in protecting your pension benefit.

We have forwarded this request to you on two prior occasions. This is the third and FINAL request for the return of your completed Annual Affidavit. **This letter will serve to notify you that your pension will be suspended effective May 1, 2011 if your completed affidavit is not received by April 15th.** In order for your pension benefit to be reinstated for any future months, your completed affidavit must be received by the 15th of the prior month.

Please return your completed affidavit promptly to avoid the interruption of your pension benefit. We have provided a return envelope for your convenience.

Thank you for your cooperation.

Sincerely,

Pension Department
Southwest Service Administrators, Inc.

Enclosure

URGENTE – REQUESTA FINAL

Marzo 9, 2011

Estimado Beneficiario:

La Junta de Fiduciarios tiene la responsabilidad de confirmar que cada pensionado o beneficiario esta recibiendo personalmente el pago mensual de beneficios, ya sea por cheque o depósito directo. La junta tambien es responsable de verificar el estatus de empleo y discapacidad si la persona recibe pension por discapacidad. La declaracion adjunta, una vez se haya recibido de cada miembro elegible, ayudara a la junta de fiduciarios en la proteccion de su beneficio de pension.

Hemos enviado esta requesta a usted en dos ocasiones anteriores. Esta es la tercera y ULTIMA solicitud para la devolucion de su declaracion anual. **Esta carta sirve para notificarle que su pension sera suspendida a partir del 1 de mayo 2011 si su declaracion completo no se recibe para el 15 de april.** Para que su beneficio de pensión sea reintegrado por cualquier próximo mes, su formulario se debe recibir antes del día 15 del mes anterior.

Por favor regresa esta formulario completó de immediate para evitar la interrupción de su pensión. Hemos incluido un sobre de retorno para su conveniencia.

Gracias por su cooperación. Si tiene alguna pregunta, por favor llame a la oficina del Fondo.

Atentamente,

Departamento de Pensiones
Southwest Service Administrators, Inc .

Apéndice

**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 # _____ 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. **AN ORIGINAL SIGNATURE IS REQUIRED FOR THIS DECLARATION.**

SIGNATURE

DATE