



DESERT STATES EMPLOYERS AND UNITED FOOD & COMMERCIAL WORKERS UNIONS PENSION PLAN

RE: PENSION BENEFIT APPLICATION

Dear Participant:

We are pleased to furnish Pension Application forms to you. Complete all forms thoroughly to the best of your ability and return them to the Fund Office as soon as you are able, so that the retirement process may begin. A return envelope is provided for your convenience.

Please be aware that it may take several months to receive a response from Social Security Administration.

Please feel free to call and inquire about your retirement application process at any time.

Sincerely,

Pension Department
Southwest Service Administrators, Inc.

Enclosure

DESERT STATES EMPLOYERS AND UFCW UNIONS PENSION PLAN

2400 W. Dunlap Ave., Suite 250, Phoenix, AZ, 85021
Phone (602) 249-3582 Toll Free (800) 474-3485 Fax (602) 336-0895

APPLICATION FOR PENSION BENEFITS

(FOR PENSION OFFICE USE ONLY)
DATE RECEIVED

NAME

LAST FIRST MIDDLE

ADDRESS

STREET CITY STATE ZIP

SOCIAL SECURITY # _____ PHONE # () _____

DATE OF BIRTH / / SEX: MALE FEMALE

LOCAL UNION # _____ DATE LAST WORKED IN COVERED POSITION _____

MARITAL STATUS: MARRIED LEGALLY SEPARATED DIVORCED WIDOWED SINGLE

HAVE YOU EVER BEEN DIVORCED? YES NO
IF YES, PLEASE PROVIDE A COPY OF THE DIVORCE DECREE

IS THERE A **DOMESTIC RELATIONS ORDER/PROPERTY SETTLEMENT** IN EFFECT AWARDING A PORTION OF YOUR POSSIBLE PENSION BENEFITS TO YOUR FORMER SPOUSE? YES NO
IF YES, PLEASE PROVIDE A COPY OF THE **ORDER**.

DO YOU HAVE TIME WITH THE INTERMOUNTAIN RETAIL FOOD (MEAT) PENSION PLAN? YES NO

PENSION BENEFIT APPLIED FOR: (CHECK ONE)

NORMAL (AGE 62 OR OVER) **RULE OF 85*** **EARLY** (AGE 50 TO 62)

**PLEASE CONTACT THE ADMINISTRATIVE OFFICE TO VERIFY YOUR ELIGIBILITY FOR A RULE OF 85 PENSION BENEFIT*

PAYMENT TYPE: (CHECK ONE)

PLEASE CONSIDER THESE OPTIONS CAREFULLY. PAYMENT TYPE CANNOT BE CHANGED ONCE THE PENSION STARTS

1. 50% HUSBAND AND WIFE PENSION - (PLEASE COMPLETE SPOUSE INFORMATION BELOW).
 2. 75% HUSBAND AND WIFE PENSION - (PLEASE COMPLETE SPOUSE INFORMATION BELOW).

SPOUSE'S NAME _____

SOCIAL SECURITY # _____ BIRTHDATE _____

3. MONTHLY INCOME FOR LIFE WITH NO MONTHLY BENEFIT PAYABLE AFTER MY DEATH

NORMAL OR EARLY PENSION APPLICANTS ONLY: (CHECK ONE)

START MY PENSION ON:

- A. THE FIRST DAY OF THE MONTH FOLLOWING THE DATE OF THIS APPLICATION
 B. THE FIRST DAY OF THE MONTH IMMEDIATELY FOLLOWING MY ATTAINMENT OF NORMAL RETIREMENT AGE
 C. THE FIRST DAY OF THE (MONTH) _____ (YEAR) _____ AT AGE _____

AUTHORIZATION TO RELEASE INFORMATION

SIGNATURE

DATE

PROOF OF AGE MUST BE FURNISHED BEFORE RETIREMENT BY ALL APPLICANTS

IF 50% OR 75% HUSBAND AND WIFE ANNUITY HAS BEEN ELECTED, THE SAME IDENTIFICATION RULES APPLY TO YOUR SPOUSE. YOU WILL ALSO NEED TO PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE.

ITEMS ARE LISTED BY ORDER OF PREFERENCE. IF YOU ARE UNABLE TO SUPPLY A BIRTH CERTIFICATE, **SUBMIT AT LEAST TWO OF THE OTHER DOCUMENTS SHOWN.** (THE FUND MAY REQUEST ADDITIONAL PROOF IF A CONFLICT EXISTS WITH OTHER INFORMATION OBTAINED.) ALL DOCUMENTS WILL BE RETURNED TO YOU AFTER RECORDING BY THE FUND OFFICE. (PLEASE **DO NOT** SEND ORIGINALS; COPIES ARE PERMISSIBLE.)

I SUBMIT THE FOLLOWING PROOF OF AGE:

BIRTH CERTIFICATE - **OR**

- BAPTISMAL CERTIFICATE, SIGNED BY CHURCH OFFICIAL
- CERTIFIED BIRTH REGISTRATION
- CERTIFICATE OF SOCIAL SECURITY ADMINISTRATION
- HOSPITAL BIRTH CERTIFICATE, SIGNED BY HOSPITAL ADMINISTRATION
- SIGNED STATEMENT OF PHYSICIAN OR MIDWIFE IN ATTENDANCE
- FAMILY BIBLE OR OTHER RECORD CERTIFIED BY NOTARY PUBLIC
- PASSPORT
- NATURALIZATION RECORD
- RECORD OF MILITARY SERVICE
- CERTIFIED VACCINATION RECORD
- CERTIFIED SCHOOL RECORD
- CERTIFIED LABOR UNION OR LODGE RECORDS
- INSURANCE POLICY SHOWING DATE OF BIRTH OR AGE
- CERTIFIED MARRIAGE RECORDS
- OTHER RECORDS SUCH AS SIGNED STATEMENTS FROM PERSONS HAVING KNOWLEDGE OF DATE OF BIRTH; VOTING RECORDS; POLL TAX RECEIPTS; DRIVER'S LICENSE; ETC.

ALL APPLICANTS MUST COMPLETE THIS EMPLOYMENT SECTION FULLY

EMPLOYERS	ADDRESS: CITY & STATE	LOCAL UNION #	DATES OF EMPLOYMENT FROM TO (MO/YR)	POSITION HELD (CASHIER-COURTESY CLERK-MEAT CUTTER-MANAGER)

NOTE: IF YOU HAVE ANY BREAKS IN SERVICE DUE TO MILITARY SERVICE, BE SURE TO FURNISH DISCHARGE PAPERS SHOWING **BOTH INDUCTION AND DISCHARGE DATES.**

ARE YOU CURRENTLY EMPLOYED? IF SO, WHERE?

DESCRIPTION OF PAYMENT TYPES

HUSBAND AND WIFE PENSION - OPTIONAL 50% OR 75% LEVEL

MARRIED PARTICIPANTS: THIS FORM OF PAYMENT PAYS YOU MONTHLY PENSION BENEFITS FOR LIFE. AFTER YOUR DEATH, A HUSBAND AND WIFE PENSION PAYS BENEFITS EQUAL TO 50% OR 75% (DEPENDENT UPON LEVEL SELECTED) OF YOUR MONTHLY BENEFIT TO YOUR SPOUSE FOR YOUR SPOUSE'S LIFETIME.

EXAMPLE OF A HUSBAND AND WIFE PENSION AT 50% LEVEL:

TOM AND HIS WIFE ARE BOTH AGE 61. LET US ASSUME THAT IF TOM RECEIVES EARLY PENSION BENEFITS BEGINNING AT AGE 61 IN THE FORM OF AN EARLY MONTHLY INCOME FOR LIFE, HE WILL RECEIVE A MONTHLY BENEFIT OF \$400.00. THIS MONTHLY BENEFIT WILL STOP WHEN TOM DIES AND WILL NOT CONTINUE TO HIS WIFE AFTER HIS DEATH. IF THE SAME BENEFIT IS PAID AS AN EARLY PENSION 50% HUSBAND AND WIFE, TOM'S MONTHLY BENEFIT WILL BE REDUCED TO 91% OF HIS PENSION BENEFIT, BECAUSE HE AND HIS WIFE ARE THE SAME AGE. HE WILL RECEIVE A BENEFIT OF \$364.00 PER MONTH (91% OF \$400 = \$364). UPON TOM'S DEATH THE EARLY PENSION 50% HUSBAND AND WIFE WILL PAY TOM'S WIFE A MONTHLY BENEFIT OF \$182 FOR HER LIFETIME (50% OF \$364 = \$182). THE BENEFIT REDUCTION MAY BE LARGER OR SMALLER IN OTHER CASES, DEPENDING UPON THE RELATIVE AGES OF THE EMPLOYEE AND HIS/HER SPOUSE.

MONTHLY INCOME FOR LIFE

THIS FORM OF PAYMENT PAYS YOU MONTHLY PENSION BENEFITS FOR LIFE. NO PAYMENTS ARE MADE TO A SPOUSE AFTER YOUR DEATH. THE EARLY PENSION MONTHLY INCOME FOR LIFE IS REDUCED DUE TO YOUR AGE IF YOU ARE LESS THAN NORMAL RETIREMENT AGE.

A PARTICIPANT MAY NOT MAKE ANY ELECTION TO CHANGE THE FORM OF PENSION BENEFIT PAYMENT AFTER HE HAS BEGUN TO RECEIVE PAYMENT OF HIS BENEFITS UNDER THE PLAN.

REQUIRED DISCLOSURE

ALTHOUGH THE AMOUNT OF THE MONTHLY BENEFIT PAYABLE TO YOU IS DIFFERENT FOR EACH OF THE OPTIONAL FORMS OF BENEFIT AVAILABLE UNDER THE PLAN, THE RELATIVE VALUES OF ALL THE OPTIONAL FORMS OFFERED UNDER THE PLAN ARE APPROXIMATELY EQUAL IN VALUE TO THE 50% HUSBAND AND WIFE ANNUITY.

THE RELATIVE VALUE COMPARISON IS INTENDED TO ALLOW YOU TO COMPARE THE TOTAL VALUE OF DISTRIBUTIONS PAID IN DIFFERENT FORMS. THE RELATIVE VALUE COMPARISON WAS MADE BY CONVERTING THE VALUE OF EACH OPTIONAL FORM OF BENEFIT AVAILABLE TO THE 50% HUSBAND AND WIFE ANNUITY AS THE COMMON FORM. THIS CONVERSION USES INTEREST AND LIFE EXPECTANCY ASSUMPTIONS. THE RELATIVE VALUE OF A BENEFIT IS DETERMINED BY PROJECTING THE TOTAL BENEFITS EXPECTED TO BE PAID TO YOU AND YOUR SPOUSE, IF APPLICABLE, BASED UPON STANDARD MORTALITY TABLES AND DISCOUNTED FOR 5% INTEREST. ALL COMPARISONS ARE BASED ON AVERAGE LIFE EXPECTANCIES. THE VALUE OF PAYMENTS ULTIMATELY MADE UNDER AN ANNUITY FORM OF BENEFIT WILL DEPEND ON YOUR ACTUAL LONGEVITY. YOU CAN REQUEST DETAILS REGARDING THE ACTUARIAL ASSUMPTIONS USED TO CALCULATE THE RELATIVE VALUE OF OPTIONAL FORMS OF BENEFIT BY CONTACTING THE PLAN ADMINISTRATIVE OFFICE.

HUSBAND & WIFE DECLARATION

NOTE: FEDERAL LAW REQUIRES THIS FORM TO BE COMPLETED IN ORDER TO PROCESS YOUR APPLICATION

YOU MUST COMPLETE EITHER NUMBER 1 OR NUMBER 2

1. UNMARRIED APPLICANTS

I AM NOT MARRIED

UNMARRIED EMPLOYEE SIGNATURE

DATE

NOTE: THIS CONSENT FORM MUST BE SIGNED BY YOUR SPOUSE IN THE PRESENCE OF A NOTARY PUBLIC, BUT NOT SOONER THAN 180 DAYS TO YOUR RECEIPT OF RETIREMENT BENEFITS.

GENERALLY, YOU HAVE THE RIGHT TO REVOKE YOUR WAIVER OF THE HUSBAND AND WIFE ANNUITY AND ELECTION OF AN OPTIONAL BENEFIT FORM UP UNTIL THE LATER OF YOUR ANNUITY START DATE OR SEVEN DAYS AFTER YOU ARE PROVIDED WITH THE WRITTEN EXPLANATION OF THE EFFECT OF PAYMENT OF YOUR PENSION BENEFIT IN A FORM OTHER THAN A HUSBAND AND WIFE ANNUITY. HOWEVER, IF YOU SIGN THE CONSENT TO WAIVER OF 30-DAY ADVANCE WAITING PERIOD ON PAGE 5, YOU MAY ONLY REVOKE YOUR WAIVER/ELECTION WITHIN 7 DAYS THEREAFTER. YOU MAY MAKE AS MANY WAIVER/ELECTIONS AND REVOCATIONS OF WAIVER/ELECTION AS YOU WISH WITHIN THE ABOVE-DESCRIBED ELECTION PERIOD. YOU MUST REVOKE THE WAIVER/ELECTION IN WRITING, BUT YOUR SPOUSE DOES NOT NEED TO CONSENT TO THE REVOCATION. IF YOU DECIDED TO RE-ELECT AN OPTIONAL FORM OF BENEFIT WITHIN THE ELECTION PERIOD, YOU MUST OBTAIN YOUR SPOUSE'S CONSENT IN WRITING. IF YOU REVOKE YOUR WAIVER OF THE HUSBAND AND WIFE ANNUITY, YOUR BENEFIT WILL BE PAID IN THAT FORM UNLESS YOU ELECT ANOTHER AVAILABLE BENEFIT OPTION WITHIN THE ELECTION PERIOD.

2. MARRIED APPLICANTS

I AM MARRIED AND I DO WISH TO HAVE 50% HUSBAND AND WIFE BENEFITS AUTOMATICALLY CONTINUED TO MY SPOUSE IF I DIE FIRST, AS PROVIDED BY FEDERAL LAW. I ENCLOSE PROOF OF AGE FOR MY SPOUSE AND A COPY OF OUR MARRIAGE CERTIFICATE; **OR**

I AM MARRIED AND I DO WISH TO HAVE 75% HUSBAND AND WIFE BENEFITS AUTOMATICALLY CONTINUED TO MY SPOUSE IF I DIE FIRST, AS PROVIDED BY FEDERAL LAW. I ENCLOSE PROOF OF AGE FOR MY SPOUSE AND A COPY OF OUR MARRIAGE CERTIFICATE **OR**

I DO NOT WISH TO PROVIDE FOR CONTINUED PAYMENTS TO MY SPOUSE IF I DIE FIRST. MY SPOUSE AGREES WITH THIS DECISION, AS EVIDENCED BY HIS/HER SIGNATURE IN THE "SPOUSE WAIVER" SECTION BELOW.

EMPLOYEE SIGNATURE

DATE

SPOUSE WAIVER

I DO HEREBY CERTIFY THAT I AM THE SPOUSE OF THE PERSON MAKING APPLICATION HEREUNDER FOR A PENSION BENEFIT FROM THE DESERT STATES EMPLOYERS AND UFCW UNIONS PENSION PLAN AND I DO HEREBY IRREVOCABLY WAIVE ANY COMMUNITY PROPERTY RIGHTS I MAY HAVE IN ANY PENSION PAYABLE TO MY SPOUSE FROM THE PLAN.

SPOUSE'S SIGNATURE

DATE

SIGNATURE MUST BE WITNESSED BY A NOTARY PUBLIC

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____,

NOTARY PUBLIC

CONSENT TO WAIVER 30-DAY ADVANCED WAITING PERIOD

I HAVE APPLIED FOR PENSION BENEFITS FROM THE DESERT STATES EMPLOYERS AND UNITED FOOD & COMMERCIAL WORKERS UNIONS PENSION PLAN WITH AN ANNUITY START DATE OF _____. I RECOGNIZE THAT, UNDER FEDERAL LAW AND REGULATION, MY ANNUITY STARTING DATE WOULD ORDINARILY NOT OCCUR FOR AT LEAST 30 DAYS AFTER MY SPOUSE AND I RECEIVE AN EXPLANATION OF THE PLAN'S BENEFIT OPTIONS. BECAUSE I DO NOT WANT TO WAIT, AND POSSIBLY LOSE BENEFITS AS A RESULT, AND BECAUSE THE PLAN'S 7-DAY ELECTION REVOCATION PERIOD GIVES ME AND MY SPOUSE SUFFICIENT TIME TO MAKE AN INFORMED DECISION, ACTING ON BEHALF OF MYSELF, MY HEIRS, SUCCESSORS AND ASSIGNS, I HEREBY AUTHORIZE THE TRUST TO DISPENSE WITH THE 30-DAY WAITING PERIOD AND AGREE NOT TO CHALLENGE THE VALIDITY OF MY ELECTION ONCE BENEFIT PAYMENTS BEGIN.

I HEREBY APPLY FOR A PENSION FROM THE DESERT STATES EMPLOYERS AND UNITED FOOD & COMMERCIAL WORKERS UNIONS PENSION PLAN. I ACKNOWLEDGE ALL CHOICES AND ELECTIONS HAVE BEEN MADE VOLUNTARILY.

I CERTIFY UNDER PENALTY OF PERJURY THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND CORRECT. I ALSO UNDERSTAND THAT A FALSE STATEMENT MAY DISQUALIFY ME FOR PENSION BENEFITS, AND THAT THE TRUSTEES SHALL HAVE THE RIGHT TO RECOVER ANY PAYMENTS MADE TO ME BECAUSE OF A FALSE STATEMENT.

EXECUTED THIS _____ DAY OF _____,

PARTICIPANT'S SIGNATURE

SPOUSE'S SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ DAY OF _____,

NOTARY PUBLIC

MY COMMISSION EXPIRES: _____

RETIREMENT DECLARATION

IN ORDER TO RETIRE WITH A PENSION FROM THE DESERT STATES EMPLOYERS & UFCW UNIONS PENSION PLAN (THE "PLAN"), I DECLARE AND AGREE THAT I WILL BE BOUND BY ALL THE PLAN'S RULES AND REGULATIONS, AS ESTABLISHED BY THE BOARD OF TRUSTEES OF THE PLAN AND AS AMENDED FROM TIME TO TIME. I FURTHER AGREE THAT I WILL PERSONALLY ENDORSE EACH PENSION CHECK UNLESS I HAVE AUTHORIZED THE PLAN, IN WRITING, TO DIRECTLY DEPOSIT MY BENEFITS.

I FURTHER AGREE THAT I WILL NOT BE ENTITLED TO RECEIVE PENSION BENEFITS FROM THE PLAN UNDER THE FOLLOWING TERMS AND CONDITIONS:

- ✓ BEFORE I REACH AGE 62, I SHALL NOT BE ELIGIBLE TO RECEIVE BENEFIT PAYMENTS FROM THE PLAN DURING ANY CALENDAR MONTH IN WHICH I AM WORKING OR SELF-EMPLOYED IN THE RETAIL FOOD INDUSTRY WITHIN THE STATES OF ARIZONA OR NEW MEXICO.

- ✓ AFTER I HAVE REACHED AGE 62, I SHALL NOT BE ELIGIBLE TO RECEIVE BENEFIT PAYMENTS FROM THE PLAN DURING ANY CALENDAR MONTH (OR MY EMPLOYER'S 4 OR 5 WEEK PAYROLL PERIOD) IN WHICH I WORK 40 HOURS OR MORE, OR 8 DAYS OR MORE IN EMPLOYMENT OR SELF-EMPLOYMENT WHICH IS:
 - ✓ IN THE SAME INDUSTRY IN WHICH INDIVIDUALS WHO ARE COVERED BY THE PLAN ARE WORKING; AND
 - ✓ IN THE SAME "TRADE OR CRAFT" IN WHICH I WAS WORKING WHILE COVERED BY THE PLAN (INCLUDING SUPERVISORY OR CORPORATE OFFICE POSITIONS); AND
 - ✓ IN THE STATE OF ARIZONA, NEW MEXICO OR ANY OTHER STATE COVERED BY THE PLAN.

- ✓ ACCORDING TO THE PENSION PLAN RULES, A PARTICIPANT WHO IS VESTED, MUST BEGIN RECEIVING A MONTHLY PENSION BENEFIT AFTER THE AGE OF 70 1/2 EVEN IF THEY ARE STILL WORKING.

I FURTHER REPRESENT THAT AS OF THE DATE OF THIS APPLICATION, I AM NOT ENGAGED IN THE TYPE OF EMPLOYMENT AS DESCRIBED ABOVE WHICH WOULD DISQUALIFY ME FROM RECEIVING A PENSION BENEFIT FROM THE PLAN. **I AGREE THAT IF I RETURN TO THE TYPE OF WORK DESCRIBED ABOVE, I WILL NOTIFY THE FUND OFFICE OF THIS FACT AND THAT I WILL BE OBLIGATED TO PAY ANY PENSION BENEFITS RECEIVED FOR THE MONTH(S) IN WHICH PAYMENTS SHOULD NOT HAVE BEEN MADE TO ME BECAUSE I WAS WORKING IN THE TYPE OF WORK DESCRIBED ABOVE.** I ACKNOWLEDGE THAT THE PLAN HAS A RIGHT TO RECOVER THE PENSION PAYMENTS FOR ANY SUCH MONTH(S) INCLUDING THE RIGHT TO OFFSET AGAINST FUTURE PENSION PAYMENTS AND THAT ANY UNCOLLECTED AMOUNTS AT MY DEATH MAY BE RECOUPED FROM PENSION PAYMENTS, IF ANY TO MY SURVIVING SPOUSE. **I ALSO UNDERSTAND THAT IF I RETURN TO THE TYPE OF WORK DESCRIBED ABOVE, MY RETIREE HEALTH BENEFITS WITH UNITED FOOD & COMMERCIAL WORKERS & EMPLOYERS ARIZONA HEALTH & WELFARE PLAN WILL BE TERMINATED AND I MAY NOT BE ABLE TO RE-ENROLL .**

TRUE AND CORRECT

I HEREBY REPRESENT THAT ALL OF THE INFORMATION I HAVE PROVIDED IN THE PENSION BENEFIT APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT A FALSE STATEMENT MAY DISQUALIFY ME FOR PENSION BENEFITS AND THAT THE BOARD OF TRUSTEES HAS THE RIGHT TO RECOVER ANY PAYMENTS MADE TO ME BECAUSE OF A FALSE STATEMENT. I ALSO UNDERSTAND THAT ANY WILLFULLY FALSE STATEMENT IN THIS APPLICATION CAN BE PUNISHED BY FINE AND IMPRISONMENT.

SIGNATURE

DATE

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____ Social Security Number _____
Other Name(s) Used _____ Date of Birth _____
(Include Maiden Name) (Mo/Day/Yr)

2. What kind of information do you need?

Detailed Earnings Information For the period(s)/year(s): _____
(If you check this block, tell us below why you need this information.)

 Certified Total Earnings For Each Year. For the year(s): _____
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement)

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 A. \$ _____

Do you want us to certify the information? Yes No
If yes, enter \$15.00 B. \$ 0.00

ADD the amounts on lines A and B, and enter the TOTAL amount C. \$ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name Desert States Employers & United Food & Commercial Workers Union Address 2400 West Dunlap Avenue, Suite 250
City, State & Zip Code Phoenix, AZ 85021

6. Mail Completed Form(s) To: **Exception:** If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration Social Security Administration
Division of Earnings Record Operations Division of Earnings Record Operations
P.O. Box 33003 300 N. Greene St.
Baltimore Maryland 21290-3003 Baltimore Maryland 21290-0300

Desert States Employers & UFCW
Unions Pension Plan
2400 W Dunlap Avenue, Suite 250
Phoenix, AZ 85021
(602) 249-3582



Northern Trust

ELECTRONIC DEPOSIT AUTHORIZATION FORM

I hereby make the following requests and authorizations relating to my periodic benefit payments from the employee benefit plan described below: (1) I request and authorize you to initiate credit entries to my Account indicated below; (2) I request and authorize you to initiate debit entries and adjustments for any credit entries made in error to the Account; and (3) I request and authorize the Financial Institution named below to credit and/or debit any such entries to the Account.

(Please print one character in each space allotted - abbreviate if necessary.)

1. NAME OF PARTICIPANT COMPANY

Desert States Employers & UFCW Unions Pension Plan

If you receive multiple benefits from Northern Trust, do you want this change to be applied to all plans? YES (ALL Plans) NO
If 'NO', enter only the valid plan names and plan numbers (*if known*) to which this change should be applied.

2. PARTICIPANT NAME

(First Name)

(Last Name)

3. SOCIAL SECURITY NUMBER

4. PARTICIPANT HOME ADDRESS

ADDR 1

ADDR 2

ADDR 3

ADDR 4

CITY STATE ZIP CODE

5. ACCOUNT TYPE US Checking US Savings Canadian Checking Canadian Savings

6. BANK ROUTING NUMBER (*contact your bank for this number*)

7. ACCOUNT NUMBER

8. FINANCIAL INSTITUTION NAME

I understand that you will verify the information provided above and, in the absence of a discrepancy or other unusual circumstance, will begin the direct deposit of my benefit payments within 30 days of your receipt of this form.

In the event of a discrepancy, I understand that I will be required to provide corrected information by completing a new form.

The authority granted by me on this form is to remain in full force and effect until you have received written notification of its termination in such time and in such manner as to afford you and my Financial Institution a reasonable opportunity to act on it.

I hereby discharge you from all liability whatsoever for any actions taken by you in accordance with the above request and authorization.

PARTICIPANT SIGNATURE _____ **DATE** _____

Make a copy for your records!