

**Desert States Employers & UFCW Unions Pension Plan**

c/o Southwest Service Administrators Inc.

2400 West Dunlap Ave, Suite 250

Phoenix, Arizona 85021-2811

www.southwestservicetpa.com

January 3, 2008

## **Desert States Employers & UFCW Unions Pension Plan**

Dear Recipient,

The Board of Trustees has a fiduciary responsibility to confirm that each 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 call the Fund Office.

Sincerely,

Pension Department  
Southwest Service Administrators. Inc.

Enclosure

**Southwest Service Administrators, Inc.**

*Service Is Our Middle Name*

**602-249-3582 • Toll Free: 800-474-3485 • Fax: 602-249-3795 • www.southwestservicetpa.com**

**DESERT STATES EMPLOYERS & UFCW UNIONS PENSION PLAN  
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 \_\_\_\_\_

Dates of Employment \_\_\_\_\_ Full or Part Time \_\_\_\_\_

Local Union Affiliation \_\_\_\_\_

**Federal Income Tax Withholding**

I do not wish to change my Federal Tax Withholding amount.

I do wish to change my Federal Tax Withholding amount. Please send me Federal form W-4P.

*COMPLETE THIS SECTION ONLY: IF YOU ARE RECEIVING A SOCIAL SECURITY DISABILITY BENEFIT.*

**Confirmation of Disability**

The administrative procedures of the Fund require yearly updates from all participants receiving a Disability pension. **Please submit a copy of your most recent Social Security Disability check or a copy of your 1099 that was provided by the Social Security Administration.**

Are you currently receiving a Social Security Disability Benefit?

YES       NO

Have you been able to do any substantial work in the past year?  YES       NO

I hereby declare under the penalty of perjury that all information shown by me is correct to the best of my knowledge.

**PLEASE PRINT:**

NAME \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_