

**Desert States Employers &
UFCW Unions Pension Plan**
c/o Southwest Service Administrators Inc.
2400 West Dunlap Avenue, Suite 250
Phoenix, Arizona 85021-2811

www.southwestservicetpa.com

10001

DESERT STATES EMPLOYERS & UFCW UNIONS PENSION PLAN

January 2009

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 _____

DOB _____ SOCIAL SECURITY _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE _____

SIGNATURE _____ DATE _____

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